

Dental Assistant, Advanced

AD-A218 590

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Although the words "he," "him," and "his" are used sparingly in this manual to enhance communication, they are not intended to be gender driven nor to affront or discriminate against anyone reading this text.

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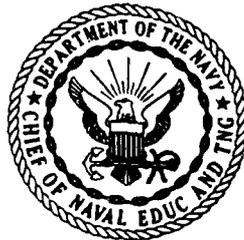
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DENTAL ASSISTANT, ADVANCED

NAVEDTRA 10678-A



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1989 Edition Prepared by
DTC Beatrice M. Harrison and DTI Robin L. Ramsey



PREFACE

Dental Assistant, Advanced, NAVEDTRA 10678-A, is a Rate Training Manual for the rating of Dental Technician, paygrades E-5 through E-7, together with the Nonresident Career Course (NRCC) form a self-study package that will enable ambitious dental technicians to fulfill the requirements of their rating. This text replaces *Dental Assistant, Advanced*, NAVEDTRA 10678.

The RTM is designed for individual study and not formal classroom instruction, and provides subject matter that relates directly to the occupational standards of E-5 through E-9 dental technicians. The NRCC provides the usual way of satisfying the requirements for completing the RTM. The set of assignments in the NRCC is designed to emphasize key points covered in the RTM.

Dental Assistant, Advanced, was prepared by the Naval School of Dental Assisting and Technology, San Diego, California for the Commander, Naval Medical Command.

Dental Assistant, Advanced, was written by Chief Dental Technician Beatrice M. Harrison, USN and Dental Technician First Class Robin L. Ramsay, USN, of the Naval School of Dental Assisting and Technology. The authors wish to thank the staff of the Naval Dental Clinic, San Diego; Naval Dental Clinic, Bethesda; Naval Hospital, Bethesda; the Naval Health Sciences and Education Training Command, Bethesda; the Naval Education and Training Program Management Support Activity, Pensacola; and the staff personnel at the Naval School of Dental Assisting and Technology for their invaluable assistance and technical review provided in this project.

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THE UNITED STATES NAVY

GUARDIAN OF OUR COUNTRY

The United States Navy is responsible for maintaining control of the sea and is a ready force on watch at home and overseas, capable of strong action to preserve the peace or of instant offensive action to win in war.

It is upon the maintenance of this control that our country's glorious future depends; the United States Navy exists to make it so.

WE SERVE WITH HONOR

Tradition, valor, and victory are the Navy's heritage from the past. To these may be added dedication, discipline, and vigilance as the watchwords of the present and the future.

At home or on distant stations we serve with pride, confident in the respect of our country, our shipmates, and our families.

Our responsibilities sober us; our adversities strengthen us.

Service to God and Country is our special privilege. We serve with honor.

THE FUTURE OF THE NAVY

The Navy will always employ new weapons, new techniques, and greater power to protect and defend the United States on the sea, under the sea, and in the air.

Now and in the future, control of the sea gives the United States her greatest advantage for the maintenance of peace and for victory in war.

Mobility, surprise, dispersal, and offensive power are the keynotes of the new Navy. The roots of the Navy lie in a strong belief in the future, in continued dedication to our tasks, and in reflection on our heritage from the past.

Never have our opportunities and our responsibilities been greater.

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INTRODUCTION TO OCCUPATIONAL STANDARDS

Superior performance of personnel is essential to the Navy, but can only be expected of personnel who meet the knowledge and skill requirements of their billets. With this in mind, a great deal of emphasis has been placed on a technique called "task analysis." As applied in the Navy, task analysis means evaluating a job by breaking it down into the many tasks that make up that job. Applying this technique to its occupational specialties (ratings), the Navy has published the *Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards, NAVPERS 18068-E*.

Occupational Standards (OCCSTDs) should be of particular interest to you. They define the minimum skills you should possess as a dental technician to perform effectively at each level of responsibility. As such, the standards form the basis of your training, your advancement, and your assignment. Dental Assistant, Basic Class "A" School had its foundation in the OCCSTDs. Each dental technician Class "C" school is based on the OCCSTDs and consequently, the contents of this rate training manual was determined on the basis of the OCCSTDs.

The OCCSTDs are contained in Section 1 of the *Manual of Navy Enlisted Manpower and Personnel Classification and Occupational Standards*, and are listed on the following pages for your convenience. As you read through them, keep in mind that they are phrased in the language of task (performance) statements. As you progress up the path of advancement, you will be expected to obtain the knowledge and skills necessary to perform such tasks. The specific knowledge required is derived from analysis data and provided to you in training programs and publications.

This rate training manual covers the OCCSTDs for Dental Technicians Second Class, First Class, Chief; Senior Chief; and Master Chief Dental Technician.

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The following list identifies the non-Navy figures used in this manual and the sources of the figures.

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CHAPTER 1

DENTAL TECHNICIAN RATING

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the mission, occupational relationships, and assignments of dental technicians.
 2. Identify the Dental Technician Navy Enlisted Classification codes, their purpose and use.
 3. Identify the requirements for advancement in the dental technician rating.
-

This Rate Training Manual (RTM) is designed as a self-study text to help you prepare to meet the occupational requirements for Dental Technician Second Class and First Class, and Chief Dental Technician. It is intended to assist you in performing the duties of an advanced dental technician and to provide a source of study for Navy-wide advancement examinations.

The information contained in the RTM is based on the Occupational Standards (OCCSTDS) listed earlier in this manual. The list was current when this RTM was prepared, but because it may have been revised, you should ask your command training officer or educational services officer for a current edition of the OCCSTDS.

This manual contains training information only and should not be interpreted as a directive. It is not intended that any portion of this text supersede current instructions, manuals, or other technical publications. The RTM is an overview of your Navy occupation: a description of the tasks involved, information or knowledge required to perform your job, and the relationship of your occupation to the overall Navy mission.

NONRESIDENT CAREER COURSE

The Nonresident Career Course (NRCC) for this RTM is provided under a separate cover and stock number. It consists of a series of assignments containing questions in multiple choice, true-false, or matching format. The questions are based on learning objectives that reflect RTM subject matter. The NRCC together with the RTM forms a self-study package.

The NRCC is designed to assist you in gaining the knowledge needed to fulfill your job requirements and to reinforce learning of the important information covered in the RTM. It will also help you prepare for Navy-wide advancement examinations.

DENTAL TECHNICIAN (DT) RATING

The Secretary of the Navy established the DT rating on 12 December 1947. Effective 2 April 1948, Navy dental technicians were authorized to wear the dental rating badge. In 1977, the enlisted rating structure was revised to combine ratings with a common purpose into one occupational field. Dental technicians and hospital corpsmen now make up Occupational Field XIV, Health Care.

The DT rating is a general service rating. Completion of Dental Assistant, Basic, Class "A" School is a requirement (except in time of emergency) for entry into the rating. Waivers may be granted for certain reservists or enlistees who have had previous training equal to the basic course.

The DT rating is comprised of personnel trained to assist dental officers in providing dental care for active duty Navy and Marine Corps personnel. During combat or in mass casualty or emergency situations, dental technicians may be directed to assist medical personnel by performing paramedical duties. Such assistance includes artificial respiration, treatment of shock, hemorrhage control, bandaging and splinting, cleansing and treatment of wounds, and preparing casualties for movement.

ASSIGNMENTS AND DUTIES

The possibility of assignment to naval dental clinics, naval hospitals, naval medical clinics, dental departments of ships and stations, Fleet Marine Force dental battalions and companies, and mobile construction battalions emphasizes the importance of professionalism, knowledge, and awareness of responsibilities. Billets and assignments are made on the basis of personnel qualifications, current dental care requirements, and the needs of the Navy.

As an advanced dental assistant, you are already aware of the general duties of a dental technician and the need to be professional and knowledgeable in all areas of dental care. As a DT2, DT1, or DTC, you may be required to perform one or more of the following duties:

- Render dental first aid
- Perform dental prophylactic treatment under the supervision of a dental officer
- Perform routine clerical, and clinical duties
- Establish and maintain records on command equipment
- Take charge of dental watch sections, dental wards, record offices, dental prosthetic laboratories, or supply sections
- Instruct personnel in formal dental technician schools and command training programs
- Supervise and instruct lower rated personnel in their duties
- Assist in the treatment and management of mass casualties and train personnel for contingency roles
- Serve as command master at arms and prepare watch, quarter, and station bills
- Assign enlisted personnel to clinical duties

NAVY ENLISTED CLASSIFICATION CODES

The *Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards*, NAVPERS 18068E, Section II, is the

official manual for Navy Enlisted Classification (NEC) code identification. The NEC structure supplements the enlisted rating structure in identifying personnel on active or inactive duty and billets in manpower authorizations. NEC codes reflect special knowledge and skills that identify personnel requirements when the rating structure is insufficient by itself for manpower management purposes.

The skills reflected by NECs are an important tool for assigning DTs to new duty stations and to duties within the command.

NEC GROUPINGS

NECs are grouped under one of the following categories:

1. **Entry Series.** These include Rating Conversion NECs and Occupational Area-defense Groupings (DG) NECs. They identify personnel who are in training for change of rating, or individuals who have received training, are in training, or have aptitude for training in identified areas.
2. **Rating Series.** These NECs relate to specific ratings.
3. **Special Series.** These NECs (e.g. Instructor, Equal Opportunity Program Specialist, Drug and Alcohol Counselor, etc.) are not related to any particular rating.

Below are the NEC codes for the DT rating.

Entry Series

DG-9730 (Medical and Dental Specialists) is assigned to personnel in paygrades E-1 through E-3 who recently enlisted in the Navy but have not yet reported to Dental Assistant, Basic, Class "A" School.

DT-8799 (Dental Technician Basic) is an entry series NEC for rating conversion to DT. It identifies aptitudes and qualifications that are not discernible from the individual's rate. This NEC is assigned to petty officers and identified strikers (other than DTs) who are in training under an approved program for a change to the DT rating.

Rating Series

DT-8703 (Dental Administrative Technician) identifies dental technicians trained to assist dental officers in organizing and managing a dental clinic

or facility. Dental technicians with this NEC perform advanced dental administrative, logistical, and financial duties. They also provide technical assistance in organizing and conducting dental health education programs, enlisted training, and fleet medical and dental support.

DT-8707 (Field Service Dental Technician) identifies dental technicians who assist the dental officer in providing dental treatment in the field. They provide technical and administrative assistance to support the mission and functions of Navy and Marine Corps field units, ensure the observance and practice of field sanitary measures, and augment medical personnel in providing emergency medical care to field or combat casualties. In addition, they prepare, review, coordinate, and maintain logistic requirements for dental field units.

DT-8732 (Dental Equipment Repair Technician) identifies dental technicians who handle the maintenance, repair, and installation of dental equipment and diagnostic devices. They monitor dental equipment safety programs; provide technical advice for dental clinic/facility design, alteration, and equipage; and administer the Dental Equipment Maintenance and Repair Program.

DT-8752 (Dental Laboratory Technician, Basic) identifies dental technicians who perform basic and intermediate level prosthodontic laboratory procedures. Such procedures include fabricating complete dentures, removable partial dentures, and other protective and restorative intraoral appliances; repairing, reconstructing, and relining dental prostheses; and performing routine equipment maintenance.

DT-8753 (Dental Laboratory Technician, Advanced) identifies dental technicians who perform and supervise the construction of fixed partial dentures, porcelain fused to metal systems, and dental ceramic arts. Personnel in paygrade E-7 with this NEC supervise dental laboratories.

DT-8765 (Dental Laboratory Technician, Maxillofacial) identifies dental technicians who assist in the clinical and technical procedures required to fabricate prostheses and appliances for oral, craniofacial, and other anatomical defects. They also construct ocular, extraoral, intraoral, and somato prostheses and molds for prosthetic rehabilitation procedures.

Most of the above DT rating series NECs require training at formal Navy schools. Some dental technicians may not have received this formal training, but they have completed the DT basic school and have been assigned a DT apprenticeship rate (DR, DA, DN) or petty officer rate.

These individuals are identified only by the rating designator of DT. DT-0000 is **NOT** an Enlisted Classification Code, but the quad zeros (0000) are used when no entry, rating, or special NEC is assigned. Special series NECs may be assigned to DTs to indicate special qualifications and training.

ADVANCEMENT

The personal advantages of advancement are: more interesting and challenging work, greater prestige, higher pay, and the satisfaction of getting ahead in your career. Also, advancement gives you personal satisfaction from knowing you have developed your skills and increased your knowledge.

The Navy also profits from your advancement. Highly trained personnel are essential to Navy operations. By advancement you increase your value to the Navy in two ways. First, you become more valuable as a technical specialist; second, you become more valuable as a person who can supervise, lead, and train others.

INCREASED RESPONSIBILITY

The extent of your contribution to the Navy depends upon your willingness and ability to accept increased responsibility as you advance. When you assumed the duties of a DT3, you accepted a certain amount of responsibility for the work of others. With each advancement, you will accept an increasing amount of responsibility in military matters and in matters relating to the occupational requirements of the DT rating. When you advance to DT2, DT1, and DTC, you will further increase your responsibilities for leadership, supervision, training, working with others, and keeping up with new developments.

The operation of a dental facility is a team effort. To be of value to the team, you need leadership ability. This ability requires a high degree of personal responsibility and technical competence.

LEADERSHIP AND SUPERVISION

As a DT2, DT1, or DTC, you are regarded as a leader and supervisor. Both officers and enlisted personnel expect you to translate general orders into detailed, practical, on-the-job language that can be followed by relatively inexperienced personnel. You must see that subordinates perform their jobs correctly, but you must be able to explain to officers any important

problems or needs of these personnel. In all military and professional matters, your responsibilities extend both upward and downward.

Along with your increased responsibilities, your ability to communicate must improve. Basic to effective communication is the ability to speak and write clearly, so others can understand. To lead, supervise, and train others, you must be able to convey exactly what you mean.

PREPARING FOR ADVANCEMENT

To prepare for advancement, you should (1) be aware of the requirements of your Occupational Standards, (2) work on the Personnel Advancement Requirement (PAR), and (3) study the RTMs and other material required for advancement. The following sections list the publications you should be familiar with and describe their contents and use.

Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards

The *Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards*, NAVPERS 18068E, defines rates and ratings by describing the Navy's requirement for enlisted skills. It establishes minimum occupational and military skills required of enlisted personnel. As such, the manual serves as the basic reference for the Enlisted Advancement System, particularly in the development of your advancement examinations and study material. It is also used by local commands as a guide in evaluating your qualifications for advancement and as a basis for training. The manual is divided into two sections.

Section I contains the Occupational Standards that define tasks required of a specific rating, and the Naval Standards, or minimum skills, required of enlisted personnel which are not rating oriented. Naval Standards are universal to all rates and ratings.

Section II contains the Navy Enlisted Classifications discussed earlier in this chapter.

Bibliography for Advancement Study

The *Bibliography for Advancement Study*, NAVEDTRA 10052, provides a list of training manuals, nonresident career courses, and other publications in support of the naval and occupational standards prescribed in Section I of the

Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards. The bibliography supporting Naval Standards is listed in the first section, titled "Military Requirements for all Ratings." This is followed by the bibliography which supports the Occupational Standards for apprenticeships (DN, HN) and the 73 individual ratings.

The bibliography is published annually by the Naval Education and Training Program Management Support Activity (NETPMSA). In studying for advancement, be sure you have the most recent edition of the bibliography. Study not only the publications listed for the next higher rate; you are also responsible for knowing the materials listed at levels below the rate for which you are working. For example, if you are studying for DT1, you should study the publications for DT1, DT2, and DT3.

The bibliography pages are arranged in three columns:

- Column 1, Bibliography, shows the long titles of references. If no parts (chapters, article, paragraph, etc.) are shown, you should be familiar with the entire publication. These references are listed by rate. Publications marked with an asterisk (*) are mandatory. This means that you must complete the RTM or publication indicated as part of the qualifications for advancement. Completion of the RTMs may be accomplished by passing the NRCC based on the RTM, or passing locally prepared examinations based on RTM content.
- Column 2, Test Identification Number, provides the identification number, initial issue or latest major revision date, and latest change number, for most publications. Instructions (directives) are listed using their number/letter designation and change number, where necessary.
- Column 3, Course Identification Number, lists the NAVEDTRA, NAVTRA, or NAVPERS number of the correspondence course associated with the publications listed in Column 1. Directions for ordering courses are found in the *List of Training Manuals and Correspondence Courses*, NAVEDTRA 10061.

Do not overlook the section of the bibliography that lists required and recommended

materials on Naval Standards. You must complete the RTM and NRCC for the indicated rate level before you are eligible to take the Navy-wide advancement examination.

Even though reference materials are listed in the bibliography as recommended rather than mandatory, they should be studied carefully. Advancement examination questions may come from recommended references.

Advancement Handbooks

There are two Advancement Handbooks, one for Apprenticeships (DN) and one for Petty Officers (DT3 through DTCM). These handbooks are a convenient tool for advancement study. They are divided into three sections providing information you will need to prepare for advancement.

- Part A - provides in-depth look at the enlisted advancement system and tells you how to use it in your climb up the advancement ladder.
- Part B - provides the Naval Standards and supporting references for paygrades E4 through E9, to help you prepare for the required military leadership examination. Remember you must pass this test for the paygrade you are trying for as an eligibility requirement for advancement.
- Part C - provides the Occupational Standards and supporting references for each rate within your rating. Occupational Standards are the **MINIMUM** tasks you are required to perform in your job and are the basis for the Navy-wide Advancement Examination.

NETPMSA produces these booklets, but distribution is **NOT** automatic. Check with your command training officer or educational services officer to obtain a copy of the Advancement Handbook required for your rating.

Personnel Advancement Requirement

One of the requirements to determine eligibility for advancement is the completion of the *Personnel Advancement Requirement (PAR)*, NAVPERS 1414/4, for your rating. The purpose of the PAR is to: (1) individualize advancement requirements for each rating and rates within the

rating, and (2) provide a consolidated check list that individuals can use in preparing for advancement and that your command can use to evaluate your readiness for advancement. The PAR is applicable when seeking advancement to DT3 (E-4) through DTC (E-7). The PAR forms are revised as changes are made in advancement and occupational requirements. The revision date is indicated on the form at the top of the front page. It should be verified as current for your advancement cycle.

The PAR form is maintained by supervisors of all personnel in paygrades E-3 through E-6. As you satisfy each requirement, your supervisor makes entries in the "Date" and "Initials" columns. Once all requirements are met and initialed, an entry is made on page 4 (NAVPERS 1070/604) of your service record, indicating PAR completion. This must be done before you are considered eligible to participate in the advancement examination.

The PAR form is divided into three sections. Section I lists various administrative requirements. Section II lists formal schools and other training requirements that are mandatory unless noted as "Recommended." Section III lists occupational and military ability requirements, and is based on the current occupational and naval standards as published in the *Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards*. Each item is a general statement of what an individual should be able to do at that paygrade. These requirements need not be demonstrated if overall job evaluation of the individual indicates ability to perform the tasks.

ADVANCEMENT REQUIREMENTS

To qualify for advancement, you must fulfill certain requirements. A list of eligibility requirements for advancement and procedures for determining eligibility are provided in the *Manual of Advancement*, BUPERSINST 1430.16 series. These requirements may change, but generally you must:

1. Complete the mandatory Personnel Advancement Requirements.
2. Complete mandatory Navy training courses and RTMs.
3. Successfully complete the required service school for a particular paygrade or rating (advancement to DT3 requires completion of Dental Assistant, Basic, Class "A" School).

4. Meet minimum performance criteria. For advancement to E-5 and E-6, your performance mark average cannot be below 3.0 for a specified period. There is no minimum performance mark average for E-7 through E-9 candidates.
5. Fulfill time-in-rate (TIR) requirements. TIR eligibility is established by service in paygrade. Minimum requirements for advancement in rate are as follows:

<u>Paygrade</u>	<u>Service Requirements</u>
E-1 to E-2	6 months in paygrade E-1
E-2 to E-3	6 months in paygrade E-2
E-3 to E-4	9 months in paygrade E-3
E-4 to E-5	12 months in paygrade E-4
E-5 to E-6	36 months in paygrade E-5
E-6 to E-7	36 months in paygrade E-6
E-7 to E-8	36 months in paygrade E-7
E-8 to E-9	36 months in paygrade E-8

6. Be recommended by your commanding officer.
7. Successfully pass the military leadership examination. Military leadership examinations are applicable for advancement to paygrades E-4 through E-7.
8. Successfully compete in a Navy-wide examination based on your occupational standards. Navy-wide advancement examinations are applicable for advancement to paygrades E-4 through E-7.
9. In addition to the advancement examination, candidates for E-7 whose final multiple scores are high enough will be designated PASSED SELBD ELIGIBLE (Passed Selection Board Eligible). This means that their records will be placed before the Chief Petty Officer (CPO) Selection Board, convened at Naval Military Personnel Command (NMPC). The board is charged with reviewing all records for those candidates who are board eligible for each rating. Authorizations for those to be advanced to CPO are based on recommendations from this board.
10. Personnel in the paygrades of E-7 and E-8 compete only in a selection board process for advancement to the next higher paygrade.

Because the requirements may change from time to time, you should always check with your

leading petty officer or training officer to determine your eligibility for advancement.

ADVANCEMENT OPPORTUNITIES FOR PETTY OFFICERS

Promotion to Chief Petty Officer is a goal shared by most enlisted personnel, but it is not the end of the line. You may advance to Senior Chief Petty Officer, Master Chief Petty Officer, or Commissioned Officer status. These paths are open to men and women who demonstrate outstanding professional ability, leadership, military responsibility, and moral integrity.

Preparation for, and advancement to, Senior Chief or Master Chief Petty Officer follow much the same pattern as for the lower rates. Successfully competing in a Navy-wide examination is NOT a requirement. Final selection for advancement is made by a selection board.

Commissioned Officer

The Navy has two inservice procurement programs through which qualified dental technicians may earn a commission: the Medical Service Corps (MSC) Inservice Procurement Program and the Medical Enlisted Commissioning Program (MECP). See your Command Career Counselor for further information and suggestions on preparation.

MSC officers are assigned to medical and dental commands to supervise administrative procedures. The specific intent of the inservice procurement program is to provide a path of advancement to commissioned officer status for outstanding dental technicians and hospital corpsmen in paygrades E-6 through E-9. Eligibility requirements are detailed in NAVMILPERS-COMINST 1120.1 series.

The program is extremely competitive. Should you desire an appointment in the Medical Service Corps, begin preparing early in your career.

The MECP affords Navy medical department enlisted personnel an opportunity to complete the requirements for a Baccalaureate Degree in Nursing and earn a commission as a Nurse Corps officer. The program is an upward mobility opportunity for outstanding dental technicians and hospital corpsmen. MECP selectees receive full pay and allowances for their enlisted paygrades and are eligible for advancement. Tuition, fees, books, and other expenses must be paid by the selectees. Upon graduation, candidates will be appointed as Ensign, Nurse Corps, United States

Naval Reserve. Eligibility requirements and application procedures for the MECP are contained in OPNAVINST 1530.7 series.

REFERENCE LIST

BUPERSINST 1430.16 series, *Manual of Advancement*, Section I, Chapter 3, November 1986.

NAVMED P-117, *Manual of the Medical Department*, Chapter 6, July 1987 (through change 101).

NAVMILPERSCOMINST 1120.1 series, *Inservice Procurement Program for Appointment in the Medical Service Corps*, July 1979.

NAVPERS 15560, *Naval Military Personnel Manual*, Art 1020356, June 1981.

NAVPERS 18068E, *Manual of Navy Enlisted Manpower and Personnel Classifications and Occupational Standards*, Sections I and II, January 1986.

OPNAVINST 1530.7 series, *Medical Enlisted Commissioning Program (MECP)*, July 1986.

CHAPTER 2

THE NAVY MEDICAL DEPARTMENT

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the mission and functions of the Navy Medical Department.
2. Identify Navy Medical Department personnel and recognize their functions.
3. Identify the mission, functions, and organizational structure of Navy Medical Department shore activities.
4. Identify the elements of Navy Medical Department support to the Fleet Marine Force.

As you advance in rate, you will become more involved in the operation and administration of medical and dental facilities. This means you must understand not only your activity's organization, but also the overall structure of the Navy Medical Department. You must also be aware of the organizational relationships within the Department. This chapter will acquaint you with this information.

As you study this chapter, keep in mind the chain of command, i.e., the chain of positions in order of authority. From the top down, individuals within the command are delegated authority to accomplish their tasks. As a senior dental technician you are the first step in the chain for others below you. In turn, you report to your division officer, who reports to the department head, and so on up the chain. You are expected to perform in your capacity within the command.

For the Navy Medical Department to function successfully, it must operate through an effective chain of command. The organizational charts in this chapter show the chain of command for the Department. These charts, however, are only guides; internal organizational structures may vary because of differences in workload, staffing, and mission.

MISSION AND STAFFING OF THE MEDICAL DEPARTMENT

The Navy Medical Department is responsible for safeguarding and maintaining the health of

Navy and Marine Corps personnel through the promotion of physical fitness, the prevention and control of diseases and injuries and the treatment and care of the sick and injured. The Medical Department is made up of four commissioned officer corps (Medical, Dental, Medical Service, and Nurse Corps); it is also made up of physician's assistants (PAs), hospital corpsmen, and dental technicians.

The Medical Corps (MC) is responsible for treating, and caring for the sick and injured, preventing and controlling diseases, and advising commanding officers about hygiene, sanitation, safety. These responsibilities extend into many areas not often associated with the patient care such as food handling and preparation; insect, pest, and rodent control; and waste disposal.

The Dental Corps (DC) provides care to prevent and treat diseases, disabilities, and injuries of the teeth, jaws, and related structures. Dental Corps officers are also qualified in advanced life support procedures so that they may assist in the treatment of casualties during combat and contingency situations.

The Medical Service Corps (MSC) complements the Medical and Dental Corps. By specializing in health care administration, clinical support sciences, and human performance and environmental sciences, MSC officers enable the Medical and Dental Corps to fully concentrate on patient care.

The Nurse Corps (NC) provides professional nursing care to the sick and injured. They also

instruct and supervise hospital corpsmen in the theory and practice of providing nursing care.

Physician's assistants (PAs) are warrant officers assigned primary care roles in Navy medical facilities. They are academically and clinically trained to provide patient services under the supervision of a physician. These services include obtaining complete health histories, performing comprehensive physical examinations and simple diagnostic laboratory and treatment procedures, and responding to commonly encountered emergency care situations.

Hospital corpsmen assist medical officers in the prevention and treatment of diseases and injuries. They perform first-aid procedures, assist in transporting the sick and injured, and provide nursing care to patients. Like dental technicians, hospital corpsmen may receive further training in the health sciences. They may specialize in areas such as radiology, pharmacology, optometry, laboratory technology, and so forth.

As you can see, Medical Department personnel are trained to perform specialized duties. As a dental technician you will work with other Medical Department personnel to support the overall readiness of the Navy.

NAVAL MEDICAL COMMAND

The Commander, Naval Medical Command (COMNAVMEDCOM) Washington, DC, directs

the provisions of health care services for Navy and Marine Corps personnel. COMNAVMEDCOM exercises control over Medical Department shore activities and ensures the acquisition and training of medical and dental personnel.

Deputy commanders within NAVMEDCOM head six departments that develop budget and fleet support plans, health care delivery programs, medical personnel training and retention programs, readiness, and logistics programs. Combined with the work of other special assistants and advisors, their efforts enable COMNAVMEDCOM to issue technical and professional guidance that optimizes health care services.

Figure 2-1 illustrates the internal organization of the Naval Medical Command. Department and division titles indicate the major areas of concern within the Navy's health care delivery system.

GEOGRAPHIC NAVAL MEDICAL COMMANDS

Geographic naval medical commands (GEOCOMs) are the principal organizational entities of the naval regional health care delivery system. GEOCOM goals are to achieve (1) increased and improved health care services; (2) improved patient, staff, and command satisfaction with health care services; (3) more efficient and

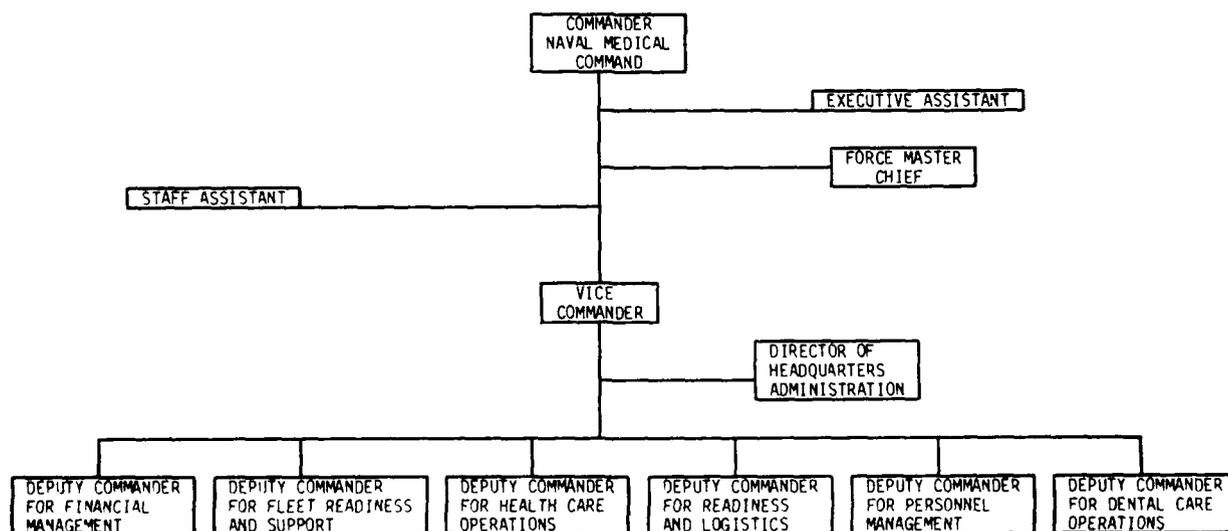


Figure 2-1.—Organizational chart of NAVMEDCOM.

economical use of health care resources; and (4) improved administration of NAVMEDCOM programs.

The GEOCOM commanders direct the provision of health care services throughout an assigned geographical area. They develop plans, objectives, priorities, and procedures to ensure that the region's health care requirements are met.

To carry out these functions, the commanders rely upon a deputy commander, special assistants, and assistant chiefs of staff.

The eight GEOCOM commanders report to COMNAVMEDCOM, Washington, DC, and exercise control over subordinate naval hospitals and medical and dental clinics. Figure 2-2 identifies the eight GEOCOMs and the activities under their control.

<p>NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION Location: Bethesda, MD</p> <p>NAVHOSP Bethesda, MD NAVHOSP Patuxent River, MD NAVMEDCL Annapolis, MD NAVMEDCL Quantico, VA NAVDENCL Bethesda, MD</p>	<p>NAVAL MEDICAL COMMAND NORTHWEST REGION Location: Oakland, CA</p> <p>NAVHOSP Oakland, CA NAVHOSP Bremerton, WA NAVHOSP Whidbey Island, WA NAVHOSP Lemoore, CA NAVMEDCL Seattle, WA NAVDENCL Bremerton, WA NAVDENCL San Francisco, CA</p>
<p>NAVAL MEDICAL COMMAND NORTHEAST REGION Location: Great Lakes, IL</p> <p>NAVHOSP Great Lakes, IL NAVHOSP Groton, CT NAVHOSP Newport, RI NAVHOSP Philadelphia, PA NAVMEDCL Portsmouth, NH NAVDENCL Newport, RI NAVDENCL Philadelphia, PA NAVDENCL Great Lakes, IL</p>	<p>NAVAL MEDICAL COMMAND SOUTHWEST REGION Location: San Diego, CA</p> <p>NAVHOSP San Diego, CA NAVHOSP Camp Pendleton, CA NAVHOSP Long Beach, CA NAVMEDCL San Diego, CA NAVMEDCL Port Hueneme, CA NAVDENCL Long Beach, CA NAVDENCL San Diego, CA</p>
<p>NAVAL MEDICAL COMMAND MID-ATLANTIC REGION Location: Norfolk, VA</p> <p>NAVHOSP Portsmouth, VA NAVHOSP Camp Lejeune, NC NAVHOSP Cherry Point, NC NAVHOSP Charleston, SC NAVHOSP Guantanamo Bay, Cuba NAVHOSP Roosevelt Roads, PR NAVHOSP Beaufort, SC NAVMEDCL Norfolk, VA NAVDENCL Camp Lejeune, NC NAVDENCL Charleston, SC NAVDENCL Norfolk, VA NAVDENCL Parris Island, SC NAVDENCL Roosevelt Roads, PR</p>	<p>NAVAL MEDICAL COMMAND PACIFIC REGION Location: Pearl Harbor, HI</p> <p>NAVHOSP Guam, MI NAVHOSP Okinawa, JA NAVHOSP Subic Bay, RP NAVHOSP Yokosuka, JA NAVMEDCL Pearl Harbor, HI NAVDENCL Guam MI NAVDENCL Okinawa, JA NAVDENCL Pearl Harbor, HI NAVDENCL Subic Bay, RP NAVDENCL Yokosuka, JA</p>
<p>NAVAL MEDICAL COMMAND SOUTHEAST REGION Location: Jacksonville, FL</p> <p>NAVHOSP Jacksonville, FL NAVHOSP Corpus Christi, TX NAVHOSP Memphis, Millington, TN NAVHOSP Orlando, FL NAVHOSP Pensacola, FL NAVMEDCL Key West, FL NAVMEDCL New Orleans, LA NAVDENCL Jacksonville, FL NAVDENCL Orlando, FL NAVDENCL Pensacola, FL</p>	<p>NAVAL MEDICAL COMMAND EUROPE REGION Location: London, England</p> <p>NAVHOSP Naples, IT NAVHOSP Rota, SP NAVDENCL Naples, IT</p>

Figure 2-2.—Geographic Naval Medical Commands, their locations and subordinate activities.

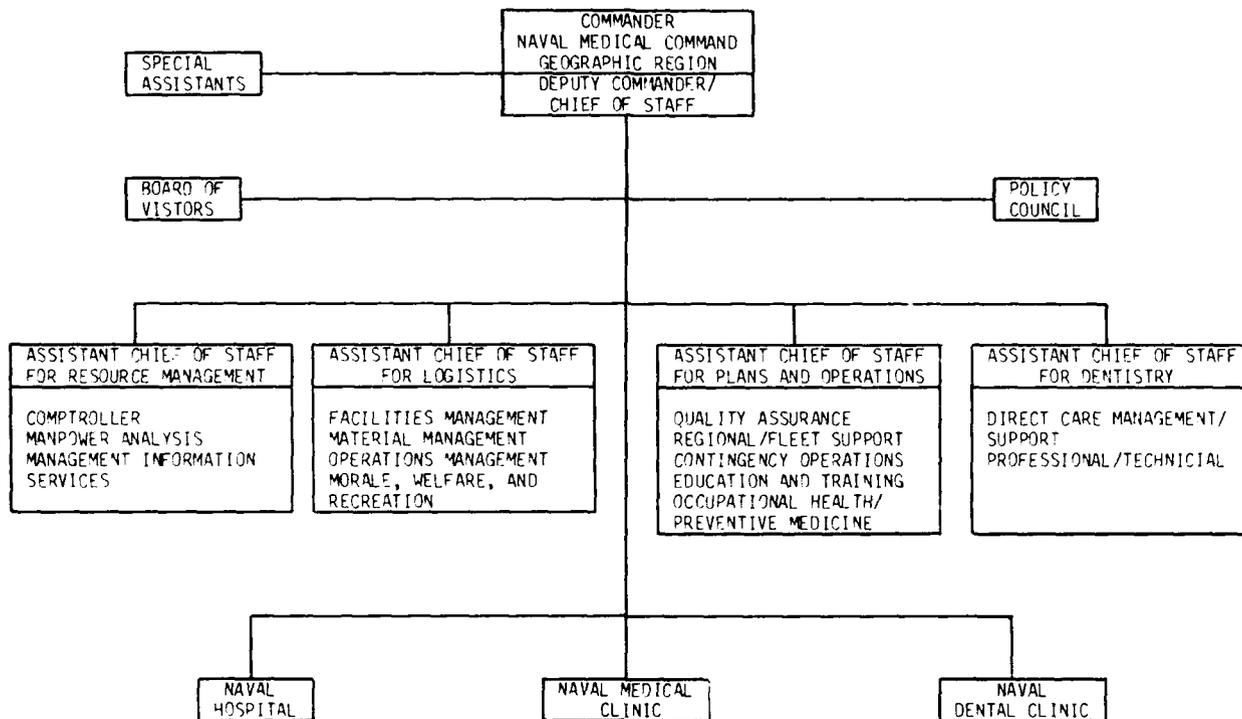


Figure 2-3.—Organizational chart of a Geographic Naval Medical Command.

Figure 2-3 shows the organizational structure of a GEOCOM. Note that dental health care is provided for under the Assistant Chief of Staff for Dentistry, who monitors dental health care programs within subordinate activities and makes recommendations for improved dental services. The other three assistant chiefs of staff do the same within their areas of expertise. Their combined efforts serve to ensure that the GEOCOM commander is fully informed of the region's health care requirements.

Naval Hospitals

Naval hospital commanding officers (COs) report to the commander of the GEOCOM for their area. The mission of a naval hospital is to:

1. Provide comprehensive emergency, outpatient, and inpatient health care services to active duty members of the Federal Uniformed Services (and other eligible beneficiaries as resources permit).
2. Cooperate with other military and civilian authorities in matters of public health, local disasters, and other emergencies.
3. Maintain required health care standards to ensure accreditation.

4. Conduct appropriate education programs for assigned military personnel to ensure that military and health care standards of conduct and performance are achieved and maintained.
5. Conduct graduate, fellowship, and postgraduate education programs (if designated and credentialed for such programs) for naval medical students and medical department officers.

Patient care provided by a hospital is based on the size and character of the patient population, health care resources available, and medical specialty requirements. Nursing, Medical, Surgical, Ancillary, and Administrative Services are headed by directorates and are broken down into departments and divisions as necessary. A naval hospital carries out its mission through the combined efforts of these five directorates.

Figure 2-4 shows the organization of a typical naval hospital. Note that the Dental Department comes under the Directorate for Surgical Services. A description of a naval hospital's Dental Department follows. You will find a detailed description of a hospital's other services and departments in NAVMEDCOMINST 5450.1 series.

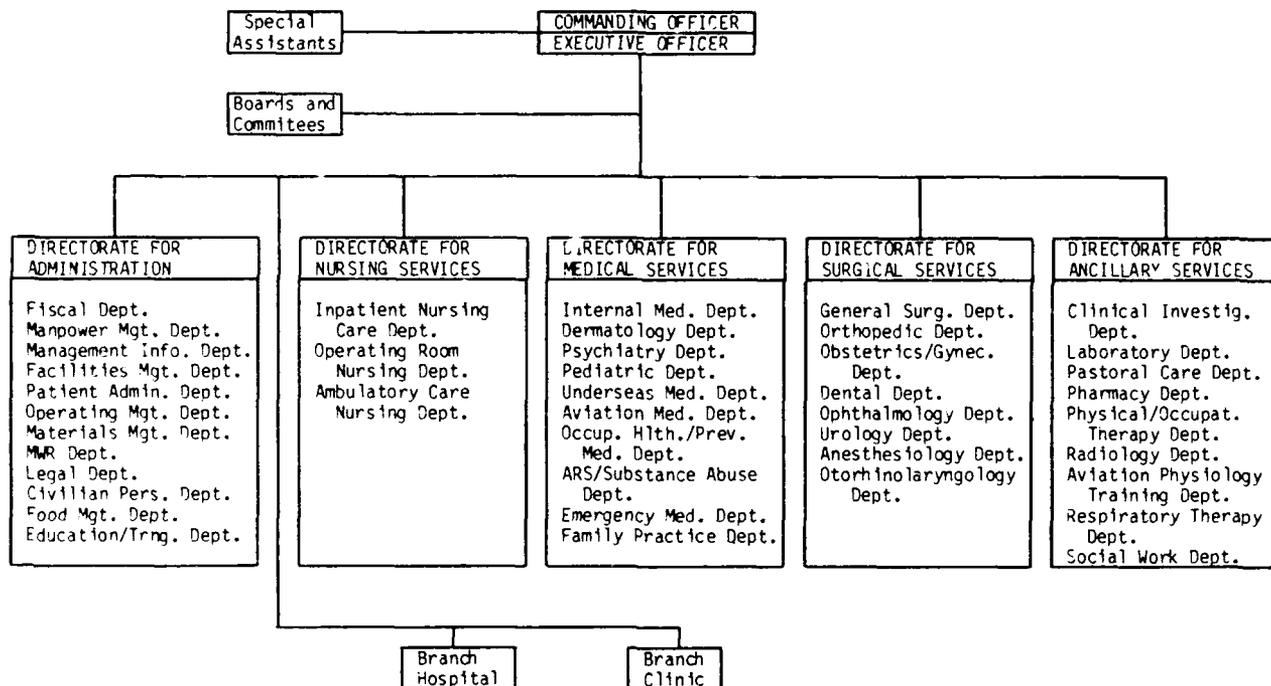


Figure 2-4.—Organizational chart of a typical Naval Hospital.

DENTAL DEPARTMENT.—The Dental Department Head reports to the Directorate for Surgical Services and coordinates dental services. Depending upon its size, available resources, and mission, a hospital's dental department may be divided into the following divisions:

Oral Diagnosis	Periodontics
Operative Dentistry	Preventive Dentistry
Oral Surgery	Endodontics
Prosthodontics	

Within the dental department of a naval hospital, your role as a dental technician is in keeping with the occupational standards. You may receive additional training in areas unique to a hospital environment; e.g., special surgical techniques, sanitary procedures, and special preventive dental care procedures for hospitalized patients.

Naval Medical Clinics

The CO of a Naval Medical Clinic (NAVMECLINIC) reports to a GEOCOM commander. NAVMECLINICs are health treatment facilities that provide general outpatient care primarily to active duty members of the Federal Uniformed Services. If it is within their space and medical staff capabilities, NAVMECLINICs may provide services to other eligible beneficiaries.

However, NAVMECLINICs provide outpatient care only; e.g., emergency treatment, physical examinations, immunizations, patient education, and preventive medicine. A medical clinic may be equipped with beds for observing patients awaiting transfer to a hospital, but that is generally the extent of its inpatient services.

Medical clinics may have branch clinics subordinate to them. Although dental services are not provided in medical clinics, support agreements and your patient management responsibilities make it necessary that you know their mission and functions.

Naval Dental Clinics

Naval Dental Clinics (NDCs) are the primary organizations within the naval dental health care delivery system. Like hospitals and medical clinics their COs report to a GEOCOM commander.

Often referred to as "headquarters," NDCs exercise administrative and operational control over subordinate dental care facilities. In addition to providing comprehensive dental services, an NDC provides:

1. Professional direction, coordination, and supervision of the dental health care delivery system within a general regional area.

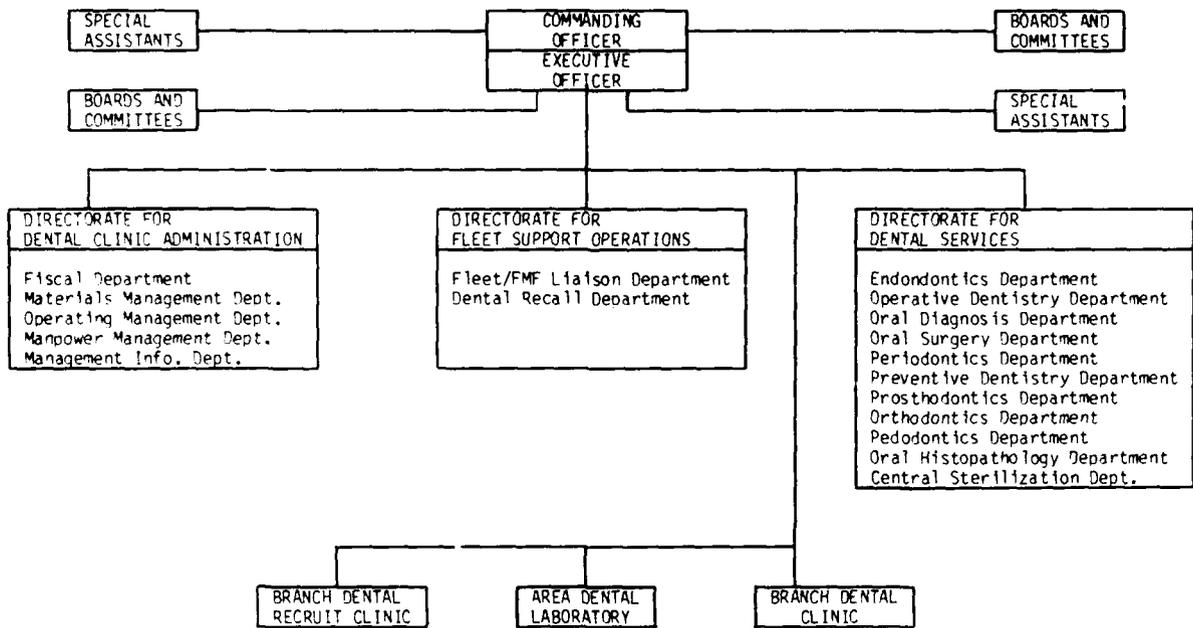


Figure 2-5.—Organizational chart of a typical Naval Dental Clinic.

2. Consolidation of administrative and management functions into one facility (the NDC performs these functions for its subordinate activities).
3. Consolidation of oral health care resources for more efficient implementation of new ideas and methods.

A description of the basic organization of an NDC follows. But first note the organizational structure of a typical NDC in figure 2-5. The CO, within the limits provided by higher authority, may establish a particular department or appoint a particular board or committee. It is up to you to know your activity's specific organizational structure.

COMMANDING OFFICER.—The CO is charged with the command, organization, and management of the NDC. The CO is responsible for accomplishing the NDC's mission efficiently and economically. Subject to the orders of higher authority, the CO exercises complete military jurisdiction over the clinic and any subordinate activities.

The CO may, when not contrary to law or regulations, delegate duties to subordinates to the maximum extent consistent with the retention of control. Delegation of authority, however, does not relieve the CO of the responsibility for the

safety, well-being, and efficiency of the entire NDC.

The CO also maintains liaison with other local medical department activities, shore commands, and units of the Operating Forces receiving dental care from the clinics.

EXECUTIVE OFFICER.—The Executive Officer (XO), is primarily responsible under the direction of the CO, for the operational readiness, provision of dental services, and good order and discipline of the entire command. The XO assists the CO in the execution of dental policies and assumes command in the CO's absence.

The XO generally assigns personnel resources within the NDC, regulates leave and liberty, and performs other duties as directed by the CO.

SPECIAL ASSISTANTS.—Special assistants are appointed as required by higher authority and as deemed necessary by the CO. They are assigned specific tasks and act as coordinators and advisors to the commanding officer on a variety of matters relating to the operation of the command. The following special assistants may be assigned:

Civilian Personnel Officer	Safety Manager
Comptroller/Fiscal Officer	Public Affairs Officer
Internal Review Officer	Command Master Chief
Chaplain	Administrative Assistant

COMMITTEES AND BOARDS.—Committees and boards are appointed by the CO to maintain ethical, professional, and quality assurance standards; to coordinate the planning and extension of programs; to evaluate a problem or situation and recommend solutions; and to conduct inventories, internal audits, and investigations. The following committees and boards are required and are common to all NDCs:

Command Policy Committee
Precious and Special Dental Metals Audit Board
Dental Library Committee
Budget Advisory Committee
Human Relations Committee

DIRECTORATES.—There are normally three directorates that report to the CO of an NDC: the Directorates for Dental Clinic Administration, Fleet/FMF Support Operations, and Dental Services. It is through the support of these directorates that the CO achieves the NDC's mission. Descriptions of each directorate are given below.

Directorate for Dental Clinic Administration.—The Director, Dental Clinic Administration, is responsible for the effective management in the areas of finance, supply, manpower, and administrative policy. The director exercises control over whatever administrative departments are needed for the efficient and effective operation of the NDC. The CO makes this decision and assigns department heads who are responsible to the director. Typical administrative departments are discussed below.

The Fiscal Department develops and administers a financial system for the managers' use in planning their operations. This department coordinates NDC budget preparation and provides continuous review of financial programs. Two possible divisions in this department are Fiscal Management and Plant Property.

The Materials Management Department administers and controls dental clinic supplies; i.e., procurement, receipt, storage, issue, inventory control, and security of all materials in its custody.

The Operating Management Department provides administration and management functions essential for dental clinic operations; i.e., security, reprographics, housekeeping, laundry, mail, and control of central files. Four possible divisions in the department are General Services, Security, Equipment Maintenance and Repair, and Facilities Management.

The Manpower Management Department directs and coordinates military personnel and manpower analysis programs; i.e., distribution, assignment, and analysis of military billets within the command, career counseling and training services, and guidance for advancement examinations and civilian personnel programs. Three possible divisions are Personnel Staffing, Career Counseling, and Civilian Personnel.

The Management Information Department provides for the accumulation, submission, and analysis of data from existing automatic data processing (ADP) systems: the Dental Information Retrieval System (DIRS), the Defense Enrollment Eligibility Reporting System (DEERS), and the Dental Management Information System (DENMIS).

Directorate for Fleet/FMF Support Operations.—The Director, Fleet/FMF Support Operations is responsible for the coordination and efficient operation of dental programs supporting fleet and FMF units. The director is the point of contact for units of the Operating Forces and branch dental clinics, and coordinates dental recall programs. If established, the two departments under the director's control are Fleet/FMF Liaison and Dental Recall. They perform such functions as their names suggest.

Directorate for Dental Services.—The Director, Dental Services, is responsible for coordinating efficient delivery of dental care. The director monitors, reviews, evaluates, and analyzes existing and proposed dental health care programs and recommends management alternatives to improve services. Only major commands have a director of dental services. Otherwise, these duties are assumed by the XO or another senior officer.

The organizational chart (figure 2-5) shows the clinical departments that can fall under the Director of Dental Services. Establishment of these departments depends on the size and character of the patient population, availability of oral health care resources, and dental specialty requirements. You should already know the functions of each clinical department, should you desire a review, refer to *Dental Assistant, Basic*, NAVEDTRA 10677-B.

Branch Dental Clinics

Branch dental clinics (BDCs) established by COMNAVMEDCOM provide oral health care at

a specific location. They report to the NDC from which they receive administrative, material, and technical support.

The BDC director coordinates clinical and administrative services within the BDC and maintains liaison with the NDC Directorates for Dental Clinic Administration and Dental Services. The BDC director ensures the maintenance of high standards of clinical practice and on-site dental recall programs. The BDC director provides professional and technical guidance and continuing education and training of subordinate dental officers and technicians.

The organization of a BDC depends on its size, the size and character of the patient population, and the desires of the NDC CO.

Branch Dental Recruit Clinics

Like the BDCs, branch dental recruit clinics are headed by a director. They are subject to the same administrative control and perform the same functions. Recruit clinics, however, have the following additional responsibilities:

1. Establish and maintain liaison with scheduling and receiving units of the Recruit Training Center (RTC) to ensure a coordinated appointment system for recruit personnel.
2. Provide feedback to the RTC commanding officer on the status of dental health care for recruits.

Because of the unique nature of their patient population, branch dental recruit clinics require at least one specialized department not found within an ordinary branch clinic, the In-Processing Department. This department coordinates the scheduling of recruits for preparing dental records, initial dental exams, and statistical data on the dental health status of recruits. Three possible divisions are Scheduling, Statistics, and Preventive Dentistry Training. The clinical departments are organized the same as those in a general BDC.

Area Dental Laboratories

As an organizational element of an NDC, area dental laboratories (ADLs) fall under the direction of the NDC commanding officer. The ADL director coordinates dental laboratory and administrative services and confers with the NDC Directorates for Dental Clinic Administration and

Dental Services on matters of mutual concern. The director ensures that the standards of laboratory services remain high and that the fabrication of all dental prostheses is in keeping with modern dental practice.

ADLs serve dental activities designated by COMNAVMEDCOM. They provide total prosthetic laboratory support and consultation services and may conduct training to enhance the professional capabilities of their technicians. ADLs generally have two departments: the Prosthetic Laboratory Department and the Supply Control Department.

The Prosthetic Laboratory Department fabricates dental and maxillofacial prostheses. The Supply Control Department ensures adequate availability of supplies, maintenance of laboratory equipment, receipt and shipment of laboratory cases, and adherence to environmental and occupational safety standards.

Although you may not be assigned to an ADL, your duties may require close liaison with its personnel. You should therefore have a knowledge of ADL capabilities.

MEDICAL DEPARTMENT TRAINING ACTIVITIES

Because medical personnel must be current on state-of-the-art health care, training is critical to the Medical Department's health care system. Therefore, in addition to the informal training programs conducted by health care facilities, the Navy Medical Department provides training in formal professional and technical schools and courses. Following are the training activities that conduct these formal programs.

Naval Health Sciences Education and Training Command

The CO of the Naval Health Sciences Education and Training Command (HSETC) reports to COMNAVMEDCOM. HSETC personnel plan for and provide education and training to health care personnel at the technical, undergraduate, graduate, and postdoctorate levels. They design, develop, standardize, and evaluate curricula for Medical Department schools and courses.

NAVAL HOSPITAL CORPS SCHOOLS.— The Naval Hospital Corps Schools in Great Lakes, IL, and San Diego, CA, are subordinate activities of HSETC, and are directed by a CO. Personnel at these commands instruct and train

enlisted members in basic health care procedures necessary to perform Hospital Corps duties; i.e., patient care, anatomy and physiology, environmental health, and drug therapy.

NAVAL SCHOOLS OF HEALTH SCIENCES.—The Naval Schools of Health Sciences (NSHS) provide advanced and specialized training to hospital corpsmen. Presently there are two schools: NSHS Bethesda and NSHS San Diego. Both fall under the direction and command of HSETC and have subordinate detachments.

The Naval School of Dental Assisting and Technology (NSDAT) is a detachment of NSHS San Diego and comes under its CO for operational guidance. NSDAT is the only school that provides rating-specific training to dental technicians. The school is directed by an officer in charge and conducts both basic and advanced dental technician training programs.

MEDICAL DEPARTMENT RESEARCH ACTIVITIES

A fundamental policy of the Navy Medical Department is to encourage and support research and development (R&D) in medical, dental, nursing, and allied sciences. This R&D is directed at finding solutions for problems affecting the health, safety, selection, and efficiency of Navy and Marine Corps personnel.

The Naval Medical Research and Development Command (NMRDC), Bethesda, MD, manages and coordinates Navy Medical Department research, development, test, and evaluation (RDT&E) programs. Under a CO and responsible to COMNAVMEDCOM, the NMRDC operates medical and dental research institutes and laboratories.

The Naval Dental Research Institute, Great Lakes, IL, conducts RDT&E in dental and allied sciences, with emphasis on oral health problems of Navy and Marine Corps recruits and operational personnel. The institute also conducts research on dental operatory and equipment design under different operating conditions. This research will ultimately affect your equipment, your health care procedures, and your working environment.

MEDICAL DEPARTMENT ENVIRONMENTAL AND PREVENTIVE MEDICINE UNITS

The Navy Environmental Health Center, Norfolk, VA, operates Navy environmental and preventive medicine units (EPMUs). The center's mission is to provide consultation, advice, and recommendations in matters of preventive medicine and environmental health. By providing technical assistance and personnel training, the units enable individual commands to recognize and eliminate hazardous conditions.

Presently, there are four EPMUs, each having a geographic area of responsibility. They help provide naval personnel an environment that is both healthful and safe.

MEDICAL DEPARTMENT SUPPORT TO THE FLEET MARINE FORCE (FMF)

As mentioned before, the Navy Medical Department provides medical support to U.S. Marine Corps personnel. As a dental technician you may serve a tour of duty with the Fleet Marine Force (FMF). Medical support to the FMF is complex, so you must first have an understanding of its overall organization and mission.

The two major components of the Marine Corps are the Operating Forces and the Supporting Establishments. As a component of the Operating Forces, the FMF is a balanced force of air and ground troops trained, organized, and equipped for offensive amphibious deployment. There are two FMFs, one on each coast of the United States (FMFPAC and FMFLANT). Each consists of a Force Headquarters, Force Service Support Groups (FSSGs), Marine Divisions, Air Wings, and Brigades.

FMF Medical Support

Medical Department personnel serving with the FMF generally provide forward and early medical care, casualty sorting and evacuation, and surgical and medical aid at each level in the chain of evacuation. They are an integral part of their unit, training with them, living with them, and accompanying them on deployments.

Although all FMF units have some medical personnel, most medical support is assigned to the FSSG. Medical personnel in this unit are organized into a medical battalion, a dental battalion,

and subordinate companies. The medical battalion provides for casualty collection, emergency treatment, temporary hospitalization, surgery, and preventive medicine measures. If you are assigned to the FMF, you will most likely work within the dental battalion.

A dental battalion has approximately 73 Dental Corps officers, 2 Medical Service Corps officers, 123 dental technicians, and 4 Marines. These personnel are distributed among four battalion companies: the Headquarters and Service (H&S) Company and three dental companies. The H&S Company is the control company of the dental battalion, which provides for battalion administration, supply, equipment repair, and transportation. The three dental companies provide dental treatment services. They can be subdivided into detachments for assignment to small or separate Marine Corps units. Dental company personnel also assist in the medical effort during mass casualty situations.

Figure 2-6 shows the medical organization of the FSSG.

SUMMARY

The Navy Medical Department's responsibility is to safeguard and maintain the health of Navy

and Marine Corps personnel. It is composed of both officers and enlisted personnel who perform specialized duties relating to patient treatment, prevention and control of diseases, and administration. As a member of the Navy Medical Department you must know its organization and perform in your capacity within it.

The Naval Medical Command, Washington, DC, is the control agency of the Navy Medical Department. COMNAVMEDCOM directs the provision of medical and dental services under the Director, Naval Medicine. Eight geographic naval medical commands, under the supervision of COMNAVMEDCOM, are the principal organizations within the naval regional health care system.

Naval hospitals, naval medical clinics, and naval dental clinics report to GEOCOM commanders and are responsible for direct patient care. These treatment facilities provide clinical services based on the size and character of the patient population and available health care resources. Consequently, the organizational structure may vary from one facility to the next. As a dental technician you may be assigned to a naval hospital, an NDC, or a BDC.

Navy Medical Department personnel receive both informal and formal training. The Naval Health Sciences Education and Training Command (HSETC) is the central organization for

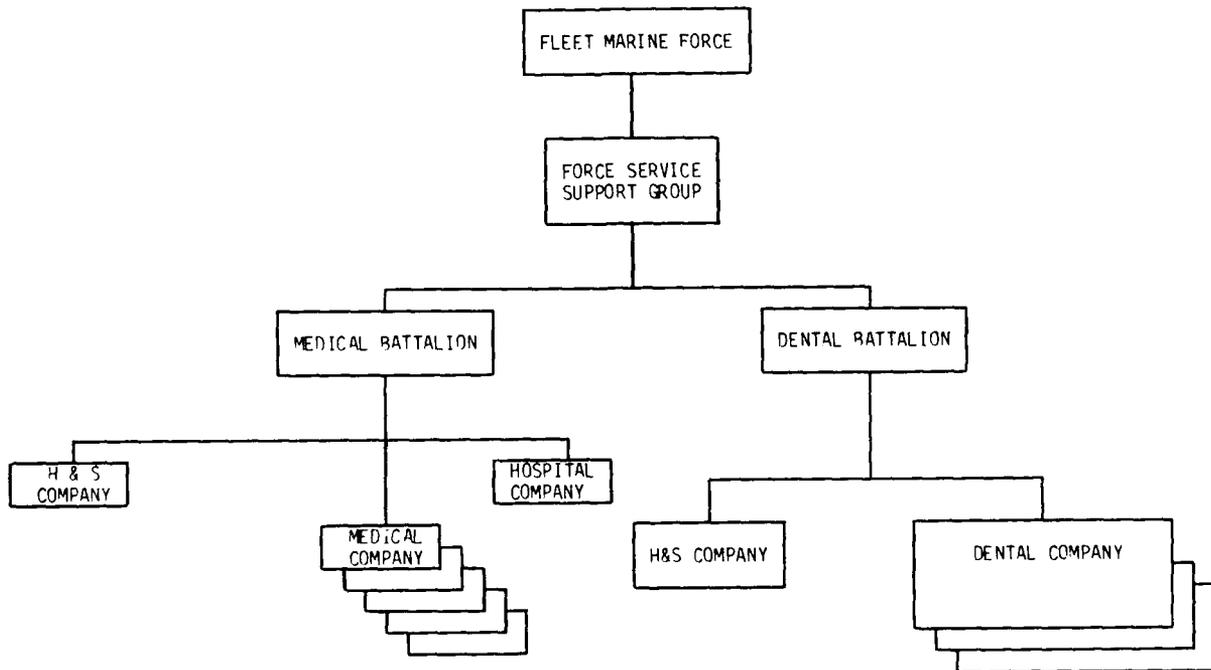


Figure 2-6.—Medical organization of the Force Service Support Group.

Medical Department training. It exercises control over hospital corpsmen and dental technician schools.

An essential element of the Medical Department's mission is the prevention and control of diseases. Navy environmental and preventive medicine units, along with research and development activities, support this mission. They enable Navy and Marine Corps personnel to live and work in a safe, healthy environment ashore and afloat.

Medical support to the Marine Corps includes units of the FMF. Although medical personnel are assigned to all units of the FMF, most medical support is within the FSSGs. Your duty with the FMF will most likely be within the dental battalion of the FSSG.

REFERENCE LIST

- BUMEDINST 5450.51 series, *Naval Hospital Corps School, Great Lakes, IL; Mission and Functions of*, October 1982.
- BUMEDINST 5450.52 series, *Naval School of Health Sciences; Mission and Functions of*, April 1978.
- BUMEDINST 5450.79 series, *Naval Dental Research Institute, Great Lakes, IL; Mission and Functions of*, February 1982.
- BUMEDINST 5450.135 series, *Naval Health Sciences Education and Training Command; Mission and Functions of*, April 1978.
- NAVMEDCOMINST 5450.1 series, *Organizational Manual for Geographic Naval Medical Commands, Naval Hospitals, Naval Medical Clinics, and Naval Dental Clinics*, August 1985.
- NAVMEDCOMINST 5450.14 series, *Naval Medical Research and Development Command, Bethesda, MD; Mission and Functions of*, May 1983.
- NAVMEDCOMINST 5450.16 series, *Navy Environmental Health Center, Norfolk, VA; Mission and Functions of*, May 1983.
- NAVMEDCOMINST 5450.28 series, *Navy Environmental and Preventive Medicine Units; Mission and Functions of*, October 1983.
- NAVMED P-117, *Manual of the Medical Department*, Chapters 1, 2, 6, 7, 8, 9, July 1987 (through change 101).
- FMF 4-5, *Medical and Dental Support*, Section 1-4, November 1980.

CHAPTER 3

LEGAL ASPECTS OF PATIENT CARE

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify consent requirements for medical and dental care.
2. Recognize a risk management incident and identify reporting requirements.
3. Identify guidelines and procedures for releasing information from health care records.
4. Identify health care provider responsibilities under the Family Advocacy Program.
5. Identify guidelines and procedures for line of duty and misconduct determinations.

Many aspects of patient management and treatment have underlying legal implications. The potential for legal entanglements exists every time a patient arrives at your facility. Although you may not realize it, many actions of health care providers and administrators are dictated by law.

In recent years, lawmakers have taken an aggressive interest in passing legislation that regulates the operation of health care facilities. Their primary goals are to ensure quality health care, to provide patients a legal remedy for malpractice, and to protect health care providers from undue legal difficulties.

This chapter outlines areas of patient care that have possible legal consequences. It also gives a brief description of the policy and procedures which apply. Keep in mind that legal issues are not always definitive. Situations vary widely and often require different actions. Never depend solely on the information in this chapter. Consult specific manuals and directives or seek professional advice.

CONSENT BY NONMILITARY PATIENTS

Before nonmilitary individuals may be given military medical care, their consent (or consent of a legal guardian) is required. Consent may be either expressed or implied, but it must always be legally sufficient. This rule applies even though nonmilitary individuals may be legally entitled to care in military medical facilities.

IMPLIED CONSENT

Implied consent may be derived from a patient's actions, even though specific words of consent are not used. For example, a patient's application for admission to a hospital is an implied consent for hospitalization. If a patient is a minor child and legally unable to give consent, a parent's request for treatment of the child may be an implied consent. Moreover, consent to treatment is implied in certain emergency situations; i.e., when the patient is unable to give or deny consent and there is a serious threat to life, health, or well-being.

EXPRESSED CONSENT

Expressed consent involves communication. The patient or legal guardian specifically states that consent is given to proposed health care. An expressed consent may be either oral or written, but there are cases where it must be in writing. For nonmilitary patients, written consent is required for:

- Any major or minor surgery involving entry into the body, either through an incision or one of the natural body openings.
- Any procedure involving use of anesthesia, except dental infiltration and dental block anesthesia.
- Any nonoperative procedure involving more than a slight risk of harm to the

patient, or the risk of a change in the patient's body structure.

- Any procedure where roentgen rays or other radioactive substances are used in the patient's treatment; e.g., cancer treatments.
- Admission of patients with psychological disorders.
- Any other procedures for which the attending physician, dentist, or administering official believes a written consent is advisable. Any questions about the need for written consent should be in favor of obtaining such consent.

Although written consent for dental care is required only in the first two situations above, your commanding officer may require it for all non-military patients. Written consent must be recorded on a Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, Standard Form 522 (figure 3-1). Such consent must be obtained prior to starting a dental treatment plan.

WHO MAY CONSENT

For a consent to be legally sufficient, it must be given by a person legally capable of giving consent. The determination of who can legally consent to health care is based on the patient's competence and the laws of the state where the treatment is performed. If competent, the patient is usually the only one who has the authority to consent. If the patient is incompetent, either by law (e.g., a minor child) or because of a physical or mental impairment, consent must come from someone legally authorized to consent on the patient's behalf. Parents and guardians can usually consent for their minor child. In some states, a spouse or next of kin may consent for a patient unable to respond.

One of the elements affecting the legality of consent is the requirement for informed consent. Persons giving consent must understand what they are consenting to, and the possible consequences of the procedure. The physician or dentist who is to perform or supervise the procedure must counsel the patient or consenting individual. The nature and expected results of the proposed treatment must be completely explained. All known risks and alternatives must be provided. Both the counseling physician or dentist and the consenting individual will confirm informed consent on the SF-522.

INCIDENT REPORTS

A risk management incident is an event that harms a patient (both military and nonmilitary), shows a potential for harm, or seriously dissatisfies a patient, staff member, or visitor. Examples of such events could include:

- A nurse puts too much silver nitrate in a newborn's eyes, causing impaired vision.
- A patient's family helps the patient out of bed despite being told not to. The patient falls and is hurt.
- A patient is fully informed and understands that the medication may have side effects. The patient requests the medication anyway and develops side effects.

Incident reports are used to identify potentially harmful situations and prevent their recurrence. They provide a record of the circumstances surrounding the event and alert the risk management team. They are an important part of your command's Quality Assurance (QA) Program.

REPORTING REQUIREMENTS

When you see, become aware of, or participate in an incident as described above, immediately make it known to the command. Your activity will have written guidelines on incident reporting. Refer to those guidelines and complete the report promptly. Generally, an incident report is required for:

- All procedural errors.
- All falls (with or without injury).
- All equipment failures during patient treatment (with or without injuries).
- All medication errors (by physicians, dentists, pharmacy personnel, etc.).
- All serious expressions of patient dissatisfaction (e.g., letters to NAVMEDCOM, CNO, Congressmen, or if there is written or implied intent to do so; schedule an appointment to see the director of service or the commanding officer).

Incident reports contain information of interest to persons filing claims or lawsuits against the Navy. Because of this, treat incident reports like other confidential documents; i.e., strictly

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES	
A. IDENTIFICATION		
1. OPERATION OR PROCEDURE _____		
B. STATEMENT OF REQUEST		
1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ <small>(Description of operation or procedure in layman's language)</small>		

which is to be performed by or under the direction of Dr. _____		
2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below named medical facility, during the course of the above-named operation or procedure.		
3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.		
4. Exceptions to surgery or anesthesia, if any, are: _____ <small>(If "none" so state)</small>		
5. I request the disposal by authorities of the below named medical facility of any tissues or parts which it may be necessary to remove.		
6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:		
a. The name of the patient and his/her family is not used to identify said pictures.		
b. Said pictures be used only for purposes of medical/dental study or research.		
<small>(Cross out any parts above which are not appropriate)</small>		
<small>(Appropriate items in Parts A and B must be completed before signing)</small>		
C. SIGNATURES		
1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.		
_____ <small>(Signature of Counseling Physician/Dentist)</small>		
2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.		
_____ <small>(Signature of Witness, excluding members of operating team)</small>	_____ <small>(Signature of Patient)</small>	_____ <small>(Date and Time)</small>
3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.		
_____ <small>(Signature of Witness, excluding members of operating team)</small>	_____ <small>(Signature of Sponsor/Legal Guardian)</small>	_____ <small>(Date and Time)</small>
PATIENT'S IDENTIFICATION <small>(For typed or written entries give Name—last, first, middle; grade, date, hospital or medical facility)</small>	REGISTER NO	WARD NO
_____	_____	_____
STANDARD FORM 522 (Rev. 10-76) General Services Administration & Interagency Comm. on Medical Records FPMR 101-11.806-8 522-109		
☆ GPO : 1984 O - 421-526 (184) NSN 7540-00-634-8165		

Figure 3-1.—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

MEDICAL FACILITY INCIDENT REPORT NAVMED 6300/11 (3-81) S/N 0105-LF-206-3055		Do not file report in Patient Treatment Record - KEEP CONFIDENTIAL (Prepare One Copy Only)	
Reporting Facility		Reporting Service	
PERSON INVOLVED IN INCIDENT	<input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> VISITOR <input type="checkbox"/> STAFF <input type="checkbox"/> OTHER		
	Name	Address	City/State/Zip Age Sex
	Social Security No.	Military Status	Duty Station (Active Duty)
	Home Telephone No.	Work Telephone No.	CONDITION OF PERSON BEFORE INCIDENT <input type="checkbox"/> N/A <input type="checkbox"/> Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Sedated <input type="checkbox"/> Senile <input type="checkbox"/> Other
IN-PATIENT ONLY	Date Admitted	Register No.	Current Diagnosis
	BED POSITION AT TIME OF INCIDENT <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Not Adjustable <input type="checkbox"/> N/A		BED RAILS <input type="checkbox"/> Up <input type="checkbox"/> Down <input type="checkbox"/> N/A
TYPE OF INCIDENT	SEDATION (Medicated Past 6 Hrs of Incident) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type _____		
	<input type="checkbox"/> Admission	<input type="checkbox"/> Cardio-Pulmonary Arrest	<input type="checkbox"/> Medication SQ/IM
	<input type="checkbox"/> Anesthesia	<input type="checkbox"/> Equip. Failure	<input type="checkbox"/> Medication IV
	<input type="checkbox"/> Bill Payment	<input type="checkbox"/> Fall	<input type="checkbox"/> Procedure
	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Fire	<input type="checkbox"/> Personal Effects/Valuable Loss
<input type="checkbox"/> Burn	<input type="checkbox"/> Medication PO	<input type="checkbox"/> Pt. Complaint/Dissatisfaction	
<input type="checkbox"/> Equipment/Surgical Supplies Loss	<input type="checkbox"/> Suicide		<input type="checkbox"/> Surgical
	<input type="checkbox"/> Treatment		<input type="checkbox"/> Report Type Incident if not listed above
Date	Time	Branch/Section/Clinic/Ward Where Incident Occurred	Exact Location of Incident
DESCRIBE INCIDENT IN CHRONOLOGICAL ORDER			
I			
N			
C			
I			
D			
E			
N			
T			
F			
A			
C			
T			
S			
PERSON PREPARING REPORT	Name of Person Preparing Report (PRINT)		Telephone No.
	Signature of Person Preparing Report		GRADE/RATE AND TITLE
ADDRESSOGRAPH			

Figure 3-2.—NAVMED 6300/11, Medical Facility Incident Report (Front).

limit the number of copies and do not include the report in the patient's medical or dental record. Forward the report exactly as your command's guidelines specify. If you are in doubt as to whether you should submit a report, submit one.

METHODS OF REPORTING

The Medical Facility Incident Report, NAVMED 6300/11, is shown in figures 3-2 and 3-3. Although it is the prescribed form for incident

reports, geographic commanders may authorize use of other reporting methods; e.g., computerized forms.

Consult your command's written guidelines when you prepare an incident report. Record only factual information; refrain from giving personal opinions.

RELEASE OF MEDICAL INFORMATION

Two federal laws, the Privacy Act of 1974 and the Freedom of Information Act (FOIA), govern the collection, maintenance, and release of Department of the Navy records. Public concern over the inner workings of the government prompted the enactment of the FOIA. The Privacy Act established a balance between the public's right to know and an individual's right to privacy.

Below you will find descriptions of these guidelines as they apply to the release of medical information from records held in your command's files. They are only highlights and do not cover every situation that may arise. Consult **SECNAVINST 5720.42** series for guidance on the FOIA, and **SECNAVINST 5211.5** series on Privacy Act matters.

FREEDOM OF INFORMATION ACT

The FOIA governs the disclosure of records to the general public. It requires the release of any government record that does not fall under an exemption (e.g., classified information, trade secrets, personal files, etc.). These exemptions are fully explained in enclosure (2) to **SECNAVINST 5720.42** series.

In keeping with the spirit and intent of the FOIA, the Department of the Navy will make available documents concerning its operations, activities, and administration. A request for such information must (1) be in writing, (2) indicate that it is a request made under the FOIA, and (3) contain a reasonable description of the record(s) desired. Commanding officers and other heads of Navy and Marine Corps activities are authorized to make records under their cognizance available to the public.

Naval records shall be withheld only when they are exempt from release under the FOIA. In any case, a written response to the request must be made within 10 working days.

The information contained in medical and dental records is personal and considered private. Unauthorized release of such information results in a clearly unwarranted invasion of personal privacy. Medical and dental records, therefore, fall under the provisions of the Privacy Act and may not be made available to the public. They are exempt from release under the FOIA.

PRIVACY ACT OF 1974

The Privacy Act provides for the protection of personal information contained in a system or records, such as health care records. You must fully comply with the Privacy Act requirements. Unauthorized release of personal information, including medical information, may subject you to a \$5,000 fine. Stated generally, the purposes of the Privacy Act are to:

1. Notify individuals when a system contains records pertaining to them and to allow them access to such records, to obtain copies, and to provide a means to amend such records.
2. Afford individuals an opportunity to prevent unauthorized use of their records.
3. Ensure adequate safeguards to prevent misuse of personal information in records.
4. Ensure that individuals' requests for notification, access, or correction of their records are acted upon promptly.
5. Ensure that personal records are collected, maintained, and used only for necessary and lawful purposes.

Following are procedures and guidelines for processing and releasing personal information from dental records maintained by your command.

Privacy Act Statement

All dental records must contain a signed Privacy Act Statement-Health Care Records, DD Form 2005. Thus the individual is informed of the purpose, routine uses, and authority for collecting the personal information. Whenever a patient's dental record is not available, or the Privacy Act Statement is missing, ask the patient to read and sign a new DD Form 2005. If an individual refuses to sign, an entry to that effect must be made on the Health Record-Dental, SF 603.

Release of Information

Route all requests for release of dental record information to your command's records management department, patient administration department, or Privacy Act Coordinator, as appropriate. Health care information must not be released without the approval of one of these offices. Following are instances when information from dental records may be disclosed.

- If individuals request information from their own dental records, it must be released to them unless it might prove injurious to their physical or mental health.
- Upon written request, information may be released to authorized representatives of individuals concerned. They must provide proof of such authorization.
- Health care information may be released to other government agencies with a proper and legitimate need to know.
- CO's of medical/dental treatment facilities may release information from dental records physically located within the command to staff members conducting research projects. Where possible, the patient's name is deleted.

Although the release of medical information is allowed as explained above, it is subject to strict controls. Chapter 23 of the *Manual of the Medical Department, NAVMED P-117*, provides specific guidance on the release of medical information. Consult it when questions or doubts exist.

Disclosure Accounting

Each activity must keep an accurate accounting of the date, nature, and purpose of each disclosure of personal information. The name and address of the person or agency to whom the disclosure is made must be recorded. Record of Disclosure-Privacy Act of 1974, OPNAV Form 5211/9 is used for this purpose. It is permanently filed in the individual's medical and dental records.

The only exception to this requirement is disclosure to Department of Defense personnel who have a need for the information compatible with the record's purpose.

FAMILY ADVOCACY PROGRAM

The Family Advocacy Program (FAP) was developed in response to an increased awareness of child and spouse abuse within Navy and Marine Corps families. Because of the many medical, legal, and social considerations involved, health care providers were often uncertain about action to be taken in such cases. Simply stated, the FAP provides policies and guidelines for identification, treatment, intervention, and prevention of abuse, neglect, sexual assault, and rape.

All medical and dental treatment facilities have local directives that outline procedures concerning the FAP. Each designates a Family Advocacy Representative (FAR) who manages the program within the command. The FAR ensures liaison with other agencies and professionals.

Command involvement, however, is not limited to the FAR. All medical and dental personnel must take an active role in the FAP. To properly aid victims, health care providers and assistants must be able to recognize abuse indicators. All personnel must be aware of the essential elements of the FAP and report situations that present physical or emotional hazards.

PREVENTIVE PROGRAM

The primary emphasis of the FAP is to prevent abuse and neglect. The goal is to assist individuals and families of the general military population to function in their relationships and social environment. Medical Department personnel often receive help from other military agencies. Family services centers, dependent wives clubs, and religious programs offer support services to help families handle the stresses of military life.

Other FAP preventive efforts are directed at "high risk" individuals and groups. These groups include families of alcoholics and drug abusers, families with handicapped or learning disabled children, families temporarily disrupted because of military duty, and families living in remote areas.

Public awareness and education campaigns encourage individuals to seek assistance. Other services help parents develop stronger bonds and communication with each other and with their children.

LEGAL AND CLINICAL GUIDELINES

Medical and dental personnel often see the results of physical and mental abuse. In many

cases, they are the first to be aware that a problem exists. Initial contact with these families is usually for treatment of an injury, and should be recorded as pertinent medical or dental history. If medical or dental evaluation/treatment arouses suspicion of abuse or neglect, a report must be made to the FAR. This report is normally written.

Military, state, and local agencies have varying types and degrees of authority for involvement in abuse and neglect cases. As information is obtained, the treatment facility's FAR evaluates the circumstances and determines which agencies must be contacted. Necessary medical and dental treatment is provided, but consent must be obtained as explained earlier in this chapter.

If the victim is considered to be in real and present danger, the duty medical or dental officer (or FAR) may take steps to remove the victim from the situation. If necessary, appropriate law enforcement, family/youth court, and state or local protection agencies are notified.

REPORTING FAP INCIDENTS

Medical and dental personnel will notify the FAR of all suspected or known cases of abuse, neglect, sexual assault, or rape that come to their attention. In the FAR's absence, the command duty officer must be notified of the situation. The FAR/command duty officer will then take action to evaluate and report the situation, and secure treatment for the victim.

LINE OF DUTY AND MISCONDUCT

As a general rule, injuries or diseases incurred by naval personnel on active duty are considered to have been incurred "in the line of duty." The presumption is that these injuries and diseases are not due to the member's own misconduct. There are, however, legal requirements to ensure that such assumptions are correct.

Findings concerning line of duty and misconduct must be made when a Navy member incurs an injury which (1) makes the individual physically unable to perform duty for more than 24 hours or (2) might result in a permanent disability. In such cases, the member's commanding officer (not medical personnel) will convene an investigation to review the circumstances. A finding of misconduct may result in an extension of enlistment (to cover the time lost), forfeiture of pay, loss of disability retirement, and possible loss of benefits from the Veterans Administration.

ENTRIES IN HEALTH CARE RECORDS

An investigation need not be made if, in the medical or dental officer's opinion (with the agreement of the member's commanding officer), the injury is not likely to result in permanent disability and was not a result of misconduct. Appropriate entries to this effect must be made in the service member's medical or dental record. These entries serve as legal documentation for the findings.

REFUSAL OF TREATMENT

When a Navy member refuses medical and dental treatment for a condition that interferes with the performance of duty, specific administrative procedures must be followed. It is possible that any resulting disability may be determined to be the result of the member's own misconduct.

There is no specific basis for a determination of misconduct when a member refuses treatment. Many legal and situational factors are involved. The *Manual of the Medical Department* provides specific guidelines and procedures.

SUMMARY

Many aspects of patient management and treatment are regulated by state and federal laws. As a member of the health care team, you must be alert to the legal implications of various situations.

Consent is required from nonmilitary individuals before they can be given military medical care. One of the elements affecting the legality of consent is the requirement for informed consent. Except in certain emergency situations, the person giving consent must understand the nature of the proposed treatment and the expected results, known risks, and alternative treatments.

Incident reports are used to identify potentially harmful situations and prevent their recurrence. Generally, you must make a report of events that harm a patient, show a potential for harm, or seriously dissatisfy a patient, staff member, or visitor.

The Privacy Act and the Freedom of Information Act govern the collection and release of Department of the Navy records.

Because dental records contain personal information, they fall under the provisions of the Privacy Act. You must fully comply with the Act's requirements.

The Family Advocacy Program provides policies and guidelines for identification, treatment, intervention, and prevention of abuse, neglect, sexual assault, and rape. To properly aid victims, you must be aware of the essential elements of the FAP and report situations that present physical or emotional hazards.

Findings concerning line of duty and misconduct must be made when a Navy member incurs an injury that might result in permanent disability or makes the member physically unable to perform duty for more than 24 hours. Entries in medical and dental records, in some instances, serve as legal documentation for such findings.

The potential for legal entanglements exists in all medical and dental treatment facilities. You must know your responsibilities for all areas covered in this chapter. When questions or doubts exist, be sure to consult the appropriate manual or directive, or seek a professional's advice.

REFERENCE LIST

BUMEDINST 5720.8 series, *Freedom of Information Act; Implementation of*, July 1976.

BUMEDINST 6320.57 series, *Family Advocacy Program (FAP)*, July 1979.

NAVMEDCOMINST 6320.3 series, *Medical and Dental Care for Eligible Persons at Navy Medical Department Facilities*, Section A, June 1986.

NAVMEDCOMINST 6320.7 series, *Guide for Quality Assurance Program*, Section F, Paragraph 6, September 1984.

NAVMED P-117, *Manual of the Medical Department*, Chapter 18, Section III, Article 18-15, and Chapter 23, Section III, July 1987 (through change 101).

JAGINST 5800.7 series, *Manual of the Judge Advocate General*, Chapter VIII, September 1985 (through change 4).

SECNAVINST 5211.5 series, *Personal Privacy and Rights of Individuals Regarding Records Pertaining to Themselves*, December 1981.

SECNAVINST 5720.42 series, *Department of the Navy Freedom of Information Act Program*, October 1982.

CHAPTER 4

OPERATIVE AND PREVENTIVE DENTISTRY

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the duties of an advanced dental assistant in operative dentistry.
2. Identify the duties of an advanced dental assistant in preventive dentistry.

As an advanced dental assistant your experience and training enable you to perform certain expanded tasks in the dental operator. Your specific duties, however, are often dictated by the size and complexity of the treatment facility in which you work. In a small dental facility you may assist the dental officer in providing patient care and, at the same time, perform a variety of other patient care and administrative duties. In a large facility you may act as a department supervisor, assisting the department head in assigning, training, and counseling enlisted dental personnel. In either case, an awareness of your responsibilities and knowledge of patient care procedures are essential for successful performance.

This chapter covers the advanced dental assisting procedures you may be required to perform in operative and preventive dentistry. Succeeding chapters discuss assisting in other dental specialties.

OPERATIVE DENTISTRY

Operative dentistry is the area of dental practice concerned with the prevention and treatment of defects in tooth enamel and dentin. Your duties in this area may include placing and removing rubber dams, applying cavity liner and bases, placing matrices and temporary restorations, and polishing restorations. You will perform these tasks under the direction of a dental officer.

RUBBER DAM

The rubber dam is a device used to isolate the operating field during a restorative dental procedure. By retracting the patient's soft tissues (cheek, tongue, and lips), the rubber dam provides

maximum access and visibility to the operating site. It also provides a clean, dry field of operation and prevents the patient from accidentally swallowing or aspirating (breathing in) debris.

To place a rubber dam, you will need rubber dam material, a rubber dam punch, forceps, retainer, holder, and napkin. The rubber dam retainer and holder you use are dictated by the operating area and the desires of the dental officer. A variety of retainers are available, but each is used to grip a particular type of tooth (see figure 4-1). The three commonly used rubber dam holders, the Woodbury, Wizard, and Young's frame, provide varying degrees of tissue retraction. The Woodbury and Wizard holders provide maximum cheek retraction and access to posterior teeth.

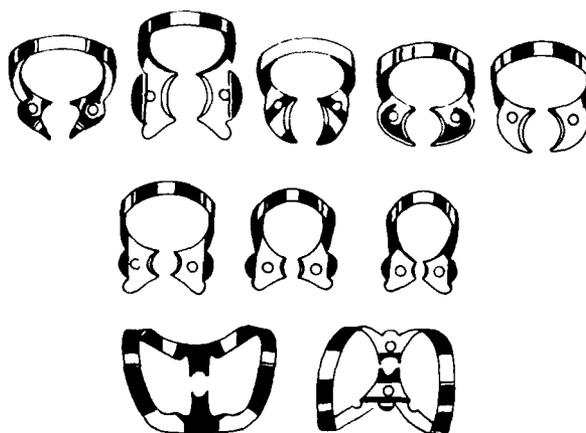


Figure 4-1.—Rubber dam retainers for molars (top row), bicuspid teeth (middle row), and anterior teeth (bottom row).

The Young's frame, commonly called the U frame, provides enough retraction for posterior procedures but is more suited to anterior restorative procedures.

Preparing the Rubber Dam

To prepare the rubber dam, you must punch holes in the material that correspond to the teeth to be isolated. Isolate at least one or two teeth posterior to the tooth being restored and punch holes to the central incisor. However, when restoring an anterior tooth, the dental officer may require that you isolate all anterior teeth in the arch.

Use a template or rubber dam stamp to mark the proper areas in which to punch holes. As a general rule, place maxillary central incisor markings 1 inch from the upper edge of the rubber dam. When isolating a single quadrant, place the marks toward the center of the dam.

Sometimes you must make adjustments to the template or rubber dam stamp markings. For example, if the teeth in the arch are not in proper alignment, you must punch holes that closely resemble the positions of the teeth (figures 4-2 and 4-3). Teeth with prominent interdental papillae will require holes spaced farther apart than teeth with flat or nonexistent interdental papillae.

Once you know which teeth to isolate, punch the rubber dam at the hole marks. Be sure to adjust the rubber dam punch to make holes large enough for molars and small enough to fit the dam snugly over anterior teeth. Using a cotton

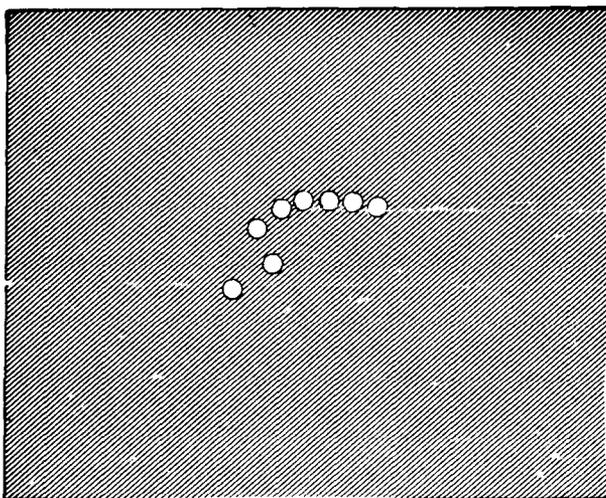
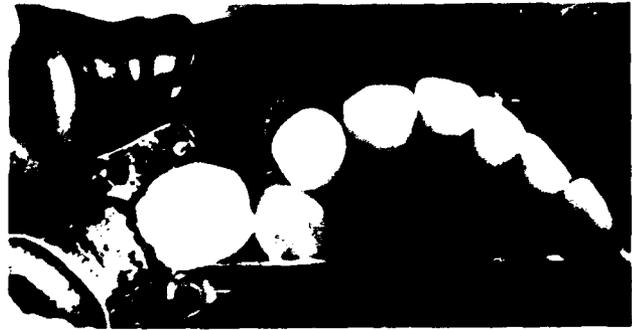


Figure 4-2.—Punched rubber dam, showing hole for tooth not in alignment with dental arch.



278.95

Figure 4-3.—Rubber dam placement with a misaligned tooth.

tipped applicator, apply silicate lubricant to the underside (side toward the teeth) of the rubber dam in the area of the punched holes. The lubricant aids in sliding the dam over the retainer and in between the teeth.

Rubber Dam Placement Procedures

To place the rubber dam, perform the following procedures:

1. Floss the interproximal spaces of the teeth to be isolated. This aids in placing the dam between the teeth and also helps you find rough edges that may cut or tear the dam.
2. Select and try a rubber dam retainer for the most distal tooth to be isolated. Tie a 24 inch length of dental floss to the retainer as a safety precaution. Use the rubber dam forceps to carry the retainer to the patient's mouth. Move the retainer gently but firmly over the contour of the tooth. The four retainer points should contact the cervical area of the tooth. Remove the retainer.
3. Apply a light coat of silicate lubricant to the patient's lips and the corners of the mouth to prevent drying and cracking.
4. Place the rubber dam and the retainer in the patient's mouth, using one of the following techniques:
 - a. Using the rubber dam forceps, place the retainer at the cervical line of the most distal tooth to be isolated. Be sure that you do not catch any gingival tissue in the retainer. Release the forceps and slip the prepared rubber dam material over the retainer.
 - b. Hold the retainer in the rubber dam forceps. Place the prepared rubber dam over the bow of the retainer. Holding

the edges of the rubber dam with your fingers, use the forceps to carry the dam and retainer into the patient's mouth. Place the retainer on the most distal tooth to be isolated.

- c. Slip the prepared rubber dam over the most distal tooth; then place the retainer on the tooth.

You can perform the first two techniques by yourself, but the third usually requires the help of another dental assistant. If during the placement (or use) of the dam the retainer continually slips off the tooth, try a different style rubber dam retainer. If necessary, use a ligature (short length of dental floss or other material tied around the neck of the tooth), dental compound, or modeling plaster instead of the rubber dam retainer (figures 4-4 and 4-5). A ligature can also be used in place of the retainer on replanted teeth and teeth with fractured roots or split crowns. If a ligature, dental compound, or modeling plaster is needed, you will have to use the third placement technique mentioned above.

5. Center the remaining holes over the corresponding teeth and slip the rubber dam into the interproximal spaces. Do not snap the material through the contact points; doing so may injure the gingiva. Use waxed dental floss to help get the dam through the contact points.
6. Once the dam is over the teeth, place a rubber dam napkin on the patient's face. Pull the dam over the napkin and attach the rubber dam holder. Adjust the dam and holder to provide gentle tension and to eliminate wrinkles.
7. Form a seal around each tooth to prevent salivary leakage. Dry the operating field and, using a spoon excavator, tuck the dam toward the gingiva around the necks of the teeth.



Figure 4-4.—Ligature holding rubber dam in place.

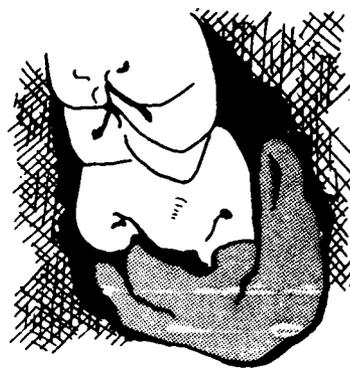


Figure 4-5.—Modeling plaster holding rubber dam in place.

Removing the Rubber Dam

After the restoration has been placed, the rubber dam is removed, and the patient's occlusion is checked. When directed by the dental officer, remove the rubber dam, using the following procedures:

1. If the rubber dam is on the maxillary arch, stretch the dam away from the teeth in the lingual direction. Cut the interproximal rubber dam material with blunt-nosed scissors. If the rubber dam is on the mandibular arch, stretch the dam away from the teeth in the facial direction and cut the interproximal dam material. Cutting the material prevents fracture of newly placed restorations.
2. Remove the rubber dam retainer with the forceps. Remove the rubber dam holder, the rubber dam, and the rubber dam napkin.
3. Wipe the patient's face gently but thoroughly with a 4x4 inch gauze pad moistened with cool water. Rinse and evacuate the patient's mouth.
4. Examine the patient's mouth and the rubber dam to ensure that all material has been removed. Use dental floss to remove any dam material stuck between the teeth.

BASES AND CAVITY LINER

Bases and cavity liner form a protective layer between the tooth pulp and the restoration. Because they do not transfer outside temperature changes and fluids to the inner dentin of the tooth, bases and liner help maintain a healthy tooth pulp. They are applied after the dental officer completes the cavity preparation.

A *base* is used to cover only the floor of a cavity preparation. Materials most often used as bases are calcium hydroxide, zinc oxide-eugenol, and zinc phosphate cements. The type of material used is determined by its effect on the tooth and the depth of the cavity preparation. For example, calcium hydroxide tends to stimulate the production of new dentin; zinc-oxide eugenol has a soothing effect on tooth pulp; and zinc phosphate cement has low thermal conductivity and high resistance to biting forces.

Cavity varnish is the material commonly used as a cavity liner. It seals the open ends of dentin tubules and helps prevent future tooth irritation. Normally, the base (if used) is applied first, and the varnish is applied over the base and all interior cavity surfaces.

The dental officer will always tell you what materials to prepare and apply. Instruments and procedures used in applying liner and bases are discussed below. You may wish to review the mixing procedures in *Dental Assistant, Basic*.

Applying Calcium Hydroxide and Zinc Oxide-Eugenol Cements

Calcium hydroxide and zinc oxide-eugenol are generally applied with a ball tip applicator (figure 4-6). You may, however, apply either material with an explorer or a small ball burnisher.

To apply the cement, first dry all tooth surfaces. Then pick up a small quantity of the prepared cement on the applicator tip and cover all exposed dentin on the cavity floor. To apply more cement, wipe the tip of the applicator with a 2 × 2 inch gauze pad. This removes any cement that may have hardened on the applicator tip. The layer of cement should be as thin as possible (less than 1/2 mm).

Remember, calcium hydroxide and zinc oxide-eugenol cements are bases and are applied only to the floor of the cavity preparation. Remove any cement on the cavity walls with an explorer. Allow the cement to harden to the tooth.

Applying Zinc Phosphate Cement

Zinc phosphate cement can be irritating to pulp tissue. Because of this, apply two layers of



278.99X
Figure 4-6.—Ball tip applicator.



278.100
Figure 4-7.—Woodson No. 2 instrument.

cavity varnish to the exposed dentin before placing the zinc phosphate cement base.

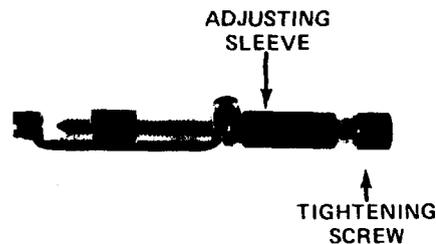
Begin by drying all tooth surfaces. Pick up the necessary quantity of mixed cement on the blade of the Woodson No. 2 instrument (figure 4-7) and place it in the cavity preparation. (The dental officer will determine the amount and composition of the cement to be used.) Dip the condenser end of the Woodson into the zinc phosphate powder on the mixing slab, and then gently condense the cement base onto the cavity floor. Allow the cement to harden for 1 minute. Use an explorer to remove any excess cement from the cavity walls.

Applying Cavity Varnish

Cavity varnish is easily applied with a small cotton pellet held in cotton forceps. Dip the pellet into the bottle of varnish. Remove the pellet and blot it gently on a 2 × 2 inch gauze pad to remove excess varnish. Paint two or three thin coats of varnish on the desired surfaces of the cavity preparation. If you are applying varnish over a base, be careful not to disturb the base. If a restorative material other than amalgam is to be used, ask the dental officer about applying cavity varnish. Normally, cavity varnish is not used under resin or composite resin restorations.

MATRICES

A matrix is a form or container used to create a wall around the tooth. It is needed for a cavity preparation that is open on the mesial, distal, facial, or lingual aspect of the tooth.



278.101X
Figure 4-8.—Tofflemire matrix retainer.

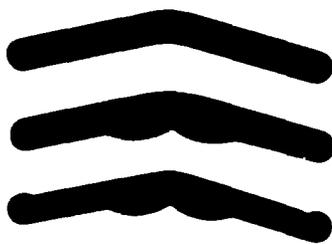


Figure 4-9.—Tofflemire matrix bands.

After applying the base and/or cavity liner, you may be required to place a matrix.

A variety of matrices are available. The matrix you use will be determined by the type and location of the restoration and the desires of the dental officer. This section covers the placement and removal of the most commonly used dental matrices.

Placing A Posterior Matrix

The Tofflemire matrix retainer together with Tofflemire matrix bands (figures 4-8 and 4-9) are commonly used for a posterior matrix. Assembly of the retainer and bands is explained in detail in *Dental Assistant, Basic*. It is suggested that you review the material in that training manual before attempting to place the Tofflemire matrix.

At the dental officer's direction, assemble the Tofflemire matrix. Then follow these steps:

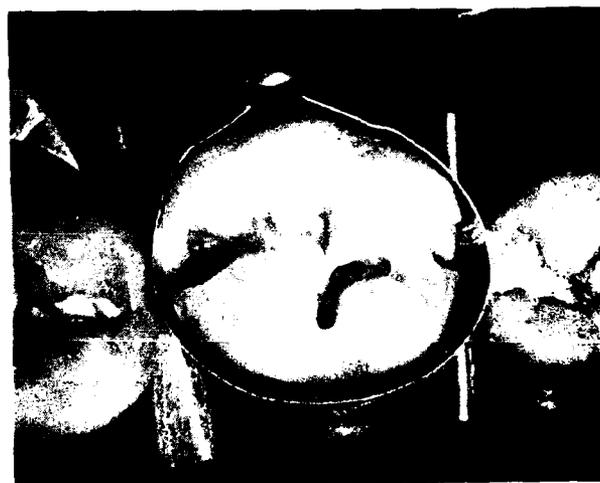
1. Position the matrix band over the tooth to be restored, ensuring that the retainer is on the facial side of the tooth. If the facial aspect of the tooth is included in the restoration, the matrix placement may be modified. In such instances, follow the dental officer's instructions.
2. Gently manipulate the matrix band into the interproximal space on either side of the tooth. It should rest just apical to the gingival extension of the cavity preparation. **DO NOT** force the band too deep; you may cause unnecessary pain and gingival trauma.
3. Once the band is in position, hold it in place by putting your thumb over the occlusal surface. Carefully tighten the band by turning the adjusting sleeve of the retainer clockwise. As you tighten the band, ensure gingival tissue is not caught between the band and the tooth, and that the band covers all margins of the cavity preparation. Continue tightening until the band fits securely against the tooth.

4. Use a ball burnisher to contour the interproximal contact area until the band touches the adjacent tooth. **DO NOT** apply too much pressure to the matrix band; doing so may fracture the remaining tooth structure. Proper contouring of the band helps restore a contact area and prevents food impaction. Double check the matrix band to ensure that it extends apically and is secured against the gingival extension of the cavity preparation.

If the mesial or distal tooth surfaces are involved, moisten a wooden wedge with water and insert it into the interproximal space at the gingival seat. Be careful not to irritate the interdental papilla or disturb the proximal contouring of the band. Insert the wedge from the lingual side to ensure maximum access. When necessary, you may insert the wedge from the facial side. If both the mesial and distal tooth surfaces are being restored, insert wooden wedges into both interproximal spaces.

Inserting the wooden wedge into the interproximal space ensures that the matrix band is tightly adapted at the gingiva and prevents overhangs. By separating the teeth slightly, the wedging procedure also ensures good interproximal contacts when the restoration is completed.

After you have contoured and wedged the matrix band, no spaces should remain between the band and the contact areas of adjacent teeth. Figure 4-10 shows a properly contoured and wedged matrix band.



278.103
Figure 4-10.—Properly contoured and wedged matrix band.

Removing Posterior Matrix

At the dental officer's direction, remove the posterior matrix retainer and band by performing the following procedures:

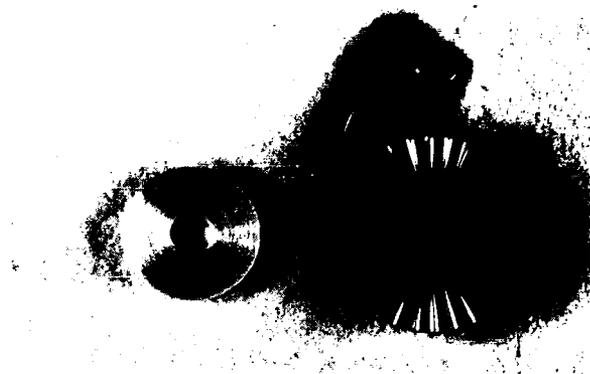
1. Gently manipulate the point of an explorer around the inside occlusal edge of the band. This contours the marginal ridge of the restoration.
2. Remove the wooden wedge(s) with hemostats or cotton forceps. Place your thumb over the occlusal surface of the restoration and the matrix band. Loosen the band by turning the adjusting sleeve of the retainer counter-clockwise.
3. Turn the tightening screw counter-clockwise and release the band from the retainer. Keeping your thumb on the occlusal surface of the restoration and band, remove the retainer.
4. To remove the band, grasp a loose end of the band with a hemostat and gently rock the band up and down, carefully manipulating it out of the interproximal space. Remove the band from the other interproximal space.

Because new restorations fracture easily, you must be extremely careful when removing the matrix band. When a restoration involves only the mesio-occlusal or disto-occlusal surfaces, remove the band from the interproximal space opposite the restored area first.

Placing and Removing an Anterior Matrix

The most commonly used anterior matrices are the plastic strip matrix (figure 4-11) and the plastic cervical matrix (figure 4-12). The type the dental officer selects depends on the tooth surfaces to be restored. For example, single surface facial restorations on anterior teeth usually require the use of cervical matrices; mesial and distal restorations require plastic strip matrices.

To place a plastic strip matrix, cut a 3 inch strip of plastic and gently work the strip into the interproximal area next to the surface being restored. If the cavity preparation is near the gingiva, it may be necessary to slide the matrix into the gingival sulcus. In this instance, **DO NOT** force the matrix too deep into the sulcus or pull the matrix across the gingiva; doing so may injure the tissue. These matrices may also be wedged with wooden wedges.



278.105
Figure 4-11.—Roll of plastic strip matrix material (left) and dispenser (right).



278.104
Figure 4-12.—Cervical matrices.

Cervical matrices come in various widths to fit teeth of different sizes. Select one of the proper width and, if necessary, use crown and bridge scissors to trim the top edge for gingival contour. After the dental officer has placed the restorative material, place the top inside edge of the cervical matrix against the cervical line of the tooth. Apply gentle pressure to the matrix.

Both matrices must remain in place until the restorative material has hardened. If light-cured composite resin materials are used, the matrices may be removed after the set has been verified with an explorer. Remove the plastic strip matrix by gently manipulating it toward the incisal edge, using a rocking motion to free it from the interproximal space. Remove the cervical matrix by gently lifting it from the restored tooth.

TEMPORARY RESTORATIONS

When a patient has extensive caries, the dental officer may excavate the caries or cut cavity

preparations on many teeth. Because all teeth may not be permanently restored during the appointment, you may be instructed to place temporary restorations. The dental officer will tell you what temporary restorative material to prepare and place in the teeth.

Because zinc oxide-eugenol cement is commonly used for temporary restorations, its use is covered here. (To review procedures for mixing zinc oxide-eugenol cement, refer to *Dental Assistant, Basic*.) Place temporary restorative material according to the following steps:

1. Dry the area by placing cotton rolls next to the tooth you are restoring. If you are working in the mandibular arch, place cotton rolls on the lingual and facial surfaces. If the tooth is in the maxillary arch, place cotton rolls on the facial surface. Use the saliva ejector to remove excess saliva.
2. Dry the cavity preparation by directing air into it from the air/water syringe or blotting it with cotton pellets.
3. Gather the desired amount of temporary restorative material on the blade end of the Woodson No. 2 instrument. Place the material in the cavity preparation and pack it with the Woodson's condensing end. Contour the restoration with the Woodson's blade, and have the patient gently close before the material is set.
4. After 5 minutes, moisten a cotton roll with water and remove any excess material from the facial and lingual tooth surfaces. Use an explorer to remove any excess material from the interproximal spaces.
5. Check the occlusion by having the patient gently tap the teeth together. Ensure that the temporary restoration does not cause an occlusion prematurely with the opposing tooth.
6. Gently rinse and evacuate the patient's mouth. Advise the patient not to chew any food for at least 1 hour. Have the dental officer inspect and approve your work.

RESTORATION POLISHING

Restorations are polished to smooth their surfaces so plaque and food will not readily adhere to them, to smooth rough edges that irritate the gingiva and tongue, and to improve their appearance. Restorations may be polished anytime after a 24 hour hardening period. The dental officer will tell you when to polish a patient's restoration.

This section presents guidelines on amalgam restoration polishing.

Polishing Amalgam Restorations

Amalgam restorations are polished to: (1) smooth rough surfaces (if necessary), (2) eliminate scratches by brushing, and (3) polish the amalgam to a glossy finish. You will use a prophylaxis handpiece, a bristle brush, flour of pumice, rubber polishing cups, two dappen dishes, tin oxide, and alcohol. If the surface is very rough, you may use finishing burs (figure 4-13) and rubber polishing points and wheels to smooth the restoration, **BUT ONLY UNDER THE DENTAL OFFICER'S DIRECT SUPERVISION.**

Polish a patient's restorations with the handpiece rotating at slow speed. Use a touch-and-go technique; i.e., hold the polishing instrument against the amalgam for very short periods (1 second or less). This avoids generating excessive heat that could irritate or damage the tooth pulp.

Begin by placing pumice in a dappen dish and moistening it with water. Mix the pumice with water until its consistency is slightly thinner than toothpaste. Taper a bristle brush to the shape of a cone, with the scissor as shown in figure 4-14.



Figure 4-13.—Finishing burs.

278.108

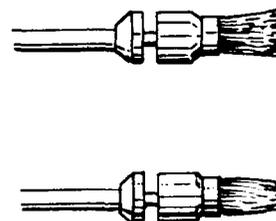


Figure 4-14.—Bristle brush: regular (top) and tapered (bottom).

Check the surface of the restoration to be polished. If the surface is very rough, you may use finishing burs and rubber polishing points and wheels to smooth the restoration. Remember, you may use these materials only under the direct supervision of the dental officer.

Once the restoration is smooth, insert the tapered brush into the prophylaxis handpiece. Dip the brush into the pumice and apply it to the restoration. With the handpiece rotating at slow speed, brush the restoration with a light touch-and-go motion. After brushing, polish all surfaces of the restoration with a rubber cup and pumice. Rinse and evacuate the patient's mouth.

When you have eliminated all the rough spots and scratches, insert a clean polishing cup into the handpiece. In a clean dappen dish mix tin oxide and alcohol until its consistency is slightly thinner than toothpaste. Because alcohol evaporates quickly, do not mix the tin oxide and alcohol until you are ready to use it. Polish the amalgam to a high gloss with the mixture. Continue polishing until the alcohol evaporates, leaving only powder on the restoration. Again, rinse and evacuate the patient's mouth. Have the dental officer inspect and approve your work.

PREVENTIVE DENTISTRY

Dental caries and periodontal disease affect over 90 percent of active duty Navy and Marine Corps personnel. These conditions can affect an individual's performance and thus the operational readiness of any Navy or Marine Corps unit. Therefore, the Navy places heavy emphasis on preventing their occurrence.

As an advanced dental assistant in a preventive dentistry department, you will actively participate in the command's preventive dentistry program. You may give oral health care presentations to individuals or groups of patients, or you may provide special preventive care to certain patients.

This section covers the requirements of the preventive dentistry program. It also outlines your patient education responsibilities and identifies special preventive care procedures.

PREVENTIVE DENTISTRY PROGRAM

All dental activities must conduct a preventive dentistry program within the guidelines set forth

by the Secretary of the Navy (SECNAVINST 6600.3 series). The program shall consist of:

- An annual oral examination.
- A topical fluoride regimen.
- Oral health counseling and evaluation of individual oral health preventive measures.
- Coordination of therapeutic dental appointments for personnel whose dental health status does not meet minimum operational readiness standards.
- A dependent children's preventive dentistry program that does not interfere with the services for active duty members or with emergency care. At least annually, children should receive:
 1. An oral screening examination.
 2. A topical application of a cariostatic agent, (i.e., fluoride).
 3. Oral health instruction.

When appropriate, pit and fissure sealants may be placed on children's teeth. If the dental activity has prosthetic capabilities, mouthguards may be provided.

A dental officer appointed as the preventive dentistry officer is responsible for planning and carrying out all aspects of the preventive dentistry program. As an advanced dental assistant you may be assigned to help the preventive dentistry officer manage the program. Your duties can include scheduling patients, helping determine budget requirements, obtaining supplies, and conducting oral health care presentations.

Most dental activities have established an annual recall system to meet program requirements. Under such a system patient appointments are coordinated with the commanding officers of the activities served. Appointments are made on an individual or group basis. Patients are sent a written notification informing them of the purpose of the recall and when they are to appear for preventive treatment. In addition to an oral examination, the actual appointment usually includes:

1. Oral health care instructions, including an explanation of the relationship between plaque, diet, fluoride, caries, and periodontal disease; the use of plaque disclosing

media; and a demonstration of plaque removal techniques.

2. Instruction in proper brushing and flossing, and evaluation of the patient's techniques.
3. A self preparation or professionally applied fluoride prophylaxis.
4. A topical fluoride regimen.

The exact nature of your activity's program is determined by the capabilities of your facility, the desires of the preventive dentistry officer, the needs of the activities served, and the needs of the patients. No matter what system your activity establishes, careful planning and close cooperation are essential to the program's success.

ORAL HEALTH CARE PRESENTATIONS

Oral health care presentations are an integral part of any preventive dentistry program. The goal is to educate patients on home care techniques and the relationship between plaque, diet, dental caries, and periodontal disease. Dental disease can be prevented when people are aware of its causes, are taught home care techniques, and are motivated to practice these techniques.

As an advanced dental assistant you may be required to prepare and conduct oral health care presentations. When doing so you become an educator and motivator with a sincere commitment to help patients prevent dental disease. You must set a good example by maintaining your own oral health. You must be knowledgeable in current preventive concepts, techniques, and scientific evidence. And, finally, you must be enthusiastic about preventive goals. Your motivation and enthusiasm will often be reflected by the patients you instruct.

A well-prepared presentation addresses the patient's needs. Older patients generally have a problem with periodontal disease, whereas dental caries is more prevalent in the young. Patients who wear a dental prosthesis must know how to care for the prosthesis as well as the oral cavity. Oral health instructions for children must be communicated in simple, easily understood words.

Although many instructional formats and techniques can be used, a well designed presentation combines visual and oral communications. There are Navy films that stress the importance of dental health and show how plaque removal helps achieve and maintain dental health. Others demonstrate proper tooth brushing and flossing

techniques. These films often entertain as they teach. Asking patients questions involves them in the presentation and helps you identify their perceptions of dental disease and home care. Demonstrations help focus attention, and pictures help to emphasize a point.

While group oral health counseling is most common, these ideas can also be used for individual instruction. An evaluation of the individual's current health status can be the basis for your instruction. Converse with the patient and gain insight on the patient's needs and expectations. Demonstrate difficult techniques; use film to reinforce learning. Whether presenting oral health care instructions to an individual or to a group, your role is to be an educator and a motivator.

SPECIAL PREVENTIVE CARE

Some patients, because of injury, disease, or other physical conditions, require special preventive care or instruction. An example would be a patient suffering from a jaw fracture, leukemia, diabetes mellitus, rheumatic fever, allergies, cardiovascular disease, or psychological problems. A few modifications are also necessary for patients who are pregnant. In these and other cases, the dental officer may develop a special treatment plan.

The Dental Health Questionnaire, NAVMED 6600/3, serves as a screening device for patients who may require special care. The dental officer reviews each patient's questionnaire and asks questions to get a full picture of the patient's health. If necessary, the dental officer consults a medical officer and prepares a special treatment plan as indicated. You must follow the treatment plan closely if you are directed to perform preventive care.

This section covers preventive care and patient education for patients with jaw fractures, hospitalized patients, and pregnant patients. Remember, the care you provide must always follow the dental officer's treatment plan and specific instructions.

Patients with Jaw Fractures and Hospitalized Patients

Patients with fractured jaws require special preventive care. When a patient's jaw has been splinted, you may provide such care under the dental officer's direct supervision.

Oral hygiene is very important for patients with jaw fractures. Proper tooth cleansing is quite

difficult and, at first, may be quite painful. These patients find that the splinting devices limit their access and tend to collect food and debris. The dental officer will recommend a tooth brushing technique specially suited to these patients. They should be taught this special technique as soon as brushing can be done without pain. You can demonstrate the technique by brushing the patient's teeth while the patient observes with a mirror.

Before brushing the patient's teeth, wipe the gingiva, tooth surfaces, and splinting devices with a cotton roll. At the direction of the dental officer, begin brushing. Use a toothbrush with very soft bristles. You can soak the bristles in warm water to gain additional softness. As you brush, explain the technique to the patient. Emphasize the importance of brushing slowly and carefully so the position of the splinting devices is not disturbed.

Provide oral health care instructions to hospitalized patients who can perform the procedures themselves. For those who cannot perform their own plaque control, daily mouth irrigation is necessary. This can be done at the bedside or, if the patients are mobile, at the hospital's dental operatory. An irrigating syringe or the air/water syringe on the dental unit may be used. If feasible, instruct patients to rinse their mouths with warm water after each meal.

Pregnant Patients

Generally, all elective dental work for a pregnant patient is postponed until the second trimester of pregnancy or until after the child is born. If the patient is feeling well, the dental officer will conduct an oral examination and may direct you to perform routine prophylaxis.

Periodontal disease is a common condition in pregnant patients. Many factors contribute to this. Hormonal changes can aggravate pre-existing periodontal conditions. Home care habits may change due to increased fatigue and nausea. Vomiting (morning sickness) temporarily increases acids in the oral cavity, leaving the teeth more prone to bacterial attack. Your understanding and

support for the patient are as important as encouraging plaque control.

With the exception of performing an oral prophylaxis (as directed by the dental officer), your primary concern for pregnant patients is oral health education. Pregnant patients are normally receptive to information that will help them have a safe and healthy pregnancy. Be ready to answer any questions the patients may have.

Many myths have arisen about decalcification and loss of the mother's teeth during pregnancy. Inform the patient that these are only myths, and review the need for good home care habits. Review the relationship between sugar, plaque, fluoride, and tooth decay. This is not only helpful to the patient, but may be helpful in feeding the child later.

A parent who is motivated about dental health will be an excellent example for the child. Emphasize the importance of fluorides for the new baby. Tell the parent about preventing "nursing bottle caries" that develops from giving a child a bottle at bedtime. Inform the patient that even milk has sugar that can cause decay.

You may be directed to schedule two or three appointments for a pregnant patient. During this time, reinforce oral health care instructions, answer questions, and evaluate the patient's plaque control. If gingival problems develop, refer the patient to the dental officer.

SUMMARY

As an advanced dental assistant you may perform certain expanded tasks in the dental operatory. You will perform such tasks only when directed by the dental officer and under the dental officer's direct supervision. Although certain techniques and procedures are outlined in this chapter, you must follow the dental officer's specific instructions.

REFERENCE LIST

SECNAVINST 6600.3 series, *Preventive Dentistry Program*, July 1984.

CHAPTER 5

ORAL SURGERY, ENDODONTICS, AND PERIODONTICS

Learning Objectives

Upon completion of the chapter you will be able to:

1. Identify the duties of an advanced dental assistant in oral surgery.
2. Identify the duties of an advanced dental assistant in endodontics.
3. Identify the duties of an advanced dental assistant in periodontics.

This chapter covers the advanced dental assisting tasks you may perform in the oral surgery, endodontics, and periodontics operatories. Your specific tasks in these areas, once again, are directed by the size and complexity of the treatment facility.

When working in endodontics, periodontics, and especially oral surgery, you must always remember the importance of asepsis, (i.e., guard against the possibility of introducing infection and cross-contamination). A number of preventive measures and techniques are discussed in detail in *Dental Assistant, Basic*. You should review these before studying the procedures outlined in this chapter.

ORAL SURGERY

As a basic dental assistant your major duty in oral surgery was to assist the dental officer during surgical procedures. As an advanced dental assistant you may be required to perform additional tasks. Such tasks include submitting tissue specimens, performing certain postoperative procedures, and maintaining surgical and emergency equipment and supplies.

TISSUE SPECIMENS

Occasionally, the dental officer may encounter an area of abnormal tissue that cannot be diagnosed by simple visual examination. The tissue is removed in a surgical procedure known as a

biopsy and sent to a pathology laboratory for microscopic analysis. The information obtained from the laboratory assists the dental officer in making a diagnosis and prescribing an appropriate treatment plan.

The tissue sample is removed from the patient and immediately placed in a specimen bottle containing formalin solution (a preserver). You can obtain these bottles from the pathology laboratory at designated medical facilities. Before submitting the specimen, ensure that the bottle is tightly closed and labeled appropriately. As a minimum, include on the label the patient's name, age, sex, the dental officer's name, your command's name, and the date of the biopsy. Be sure to include with the specimen a short biopsy report, Tissue Examination, SF 515, prepared by the dental officer.

Keep a pathology log of all tissue specimens submitted to the pathology lab. Record the following information in the log:

1. Patient's name, age, grade/rate, branch of service, and social security number.
2. Patient's status (inpatient or outpatient).
3. Location of specimen extraction, e.g., from tooth No. 17.
4. Date of surgery.
5. Date specimen submitted.
6. Oral surgeon's name.

POSTOPERATIVE TREATMENT

Postoperative treatment (POT) is the care given the patient in the hours (or days) following

oral surgery. During this period the dental officer evaluates the healing process and treats any conditions that may arise as a result of the surgery.

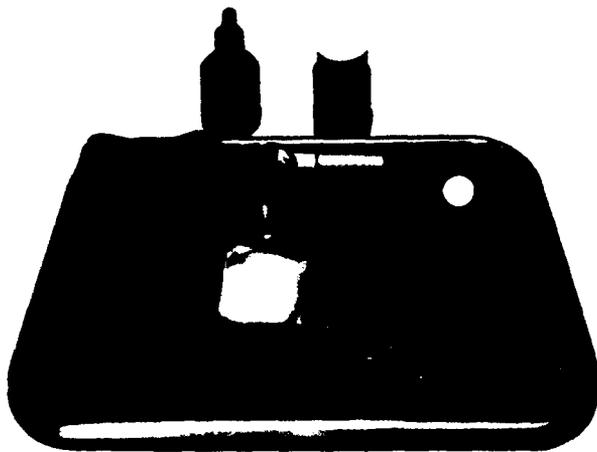
As an advanced dental assistant you may be directed by the dental officer to perform certain POT procedures. These may include treating alveolar osteitis and removing surgical sutures.

Alveolar Osteitis

Sometimes, within 2 to 5 days after a tooth extraction, the patient experiences mild to severe pain in the tooth socket. An examination by the dental officer may reveal the absence or deterioration of the blood clot and exposure of the alveolar bone. This condition is known as alveolar osteitis, or dry socket. The pain is caused by exposure of the alveolar bone to the oral environment. Treatment is provided to make the patient comfortable while the area heals.

After diagnosing the condition, the dental officer may direct you to provide POT. Figure 5-1 shows the instruments and materials used for the treatment. A bottle of eugenol (or other medication specified by the dental officer) and a container of iodoform gauze are included in the setup. Because of a patient's susceptibility to infection after oral surgery, be sure you maintain an aseptic technique during the treatment. Following are the procedures used when treating alveolar osteitis.

1. Put on a surgical cap and face mask.
2. Place the postoperative examination pack on the bracket table. Open the pack,



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Figure 5-1.—Postoperative examination setup.

touching only the outside edges of the pack. Use the inside surface of the surgical wrap as a sterile working surface during the treatment.

3. Place the container of iodoform gauze and the bottle of eugenol (or other medication) on a corner of the bracket table for later use.
4. Open a package of sterile gloves and place it on top of an instrument cabinet. Wash your hands and put on the gloves, using the scrub and gloving techniques covered in *Dental Assistant, Basic*.
5. Drape the patient by placing the sterile towel or drape on the patient's chest. Instruct the circulating assistant to fill the sterile medicine glass (or small beaker) with sterile saline solution (or other sterile irrigating solution prescribed by the dental officer). Direct the assistant to turn on and adjust the dental operating light.
6. Using a sterile disposable syringe with a blunt needle, gently irrigate the extraction site with sterile saline solution. This removes any debris that may have accumulated in the socket. Suction off the solution with a sterile surgical aspirator tip, or have the patient spit into the cuspidor.
7. Direct the circulating assistant to open the container of iodoform gauze. Grasp the end of the gauze with the cotton forceps and cut off a 1 1/2 inch strip with the scissors. Place the gauze strip on the sterile working surface and direct the circulating assistant to treat the iodoform gauze with the medication.
8. Use the cotton forceps to insert the treated iodoform gauze into the socket. Once in place, the gauze will help prevent food from collecting in the socket and protect the alveolar bone from exposure to the oral environment.

When these procedures have been completed, the patient may experience some relief (the medication soothes nerve endings in the exposed bone). However, discomfort may persist for several days. The dressing may be changed daily, or left in place for several days depending on the dental officer's directions and the patient's condition.

SUTURE REMOVAL

Surgical sutures are normally removed 3 to 5 days after insertion. The dental officer will

examine the surgical site to determine whether the sutures may be removed.

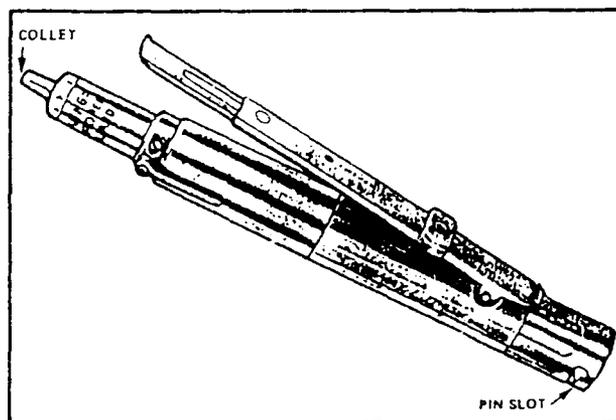
In some instances the dental officer may direct you to remove the sutures. To do this, obtain a sterile suture removal pack containing a mouth mirror, cotton forceps, scissors, 2 × 2 inch gauze pads, and a sterile towel or surgical drape. (Once again be sure to use aseptic techniques.)

Begin by checking box 17 of the patient's SF 603 to determine how many sutures were placed, then follow these procedures:

1. Don a surgical cap and face mask.
2. Place the suture removal pack on the bracket table. Open the pack, touching only the outside edges of the surgical wraps.
3. Open a package of sterile gloves, wash your hands, and put on the gloves. (Be sure to use the scrub and gloving techniques covered in *Dental Assistant, Basic*.)
4. Drape the patient. Place a sterile towel or surgical drape on the patient's chest. Have the circulating assistant turn on and adjust the dental operating light.
5. Locate and account for all the sutures placed during the surgical procedure.
6. Remove the sutures by gently lifting a suture with the cotton forceps, and using the scissors cut the suture as close to the tissue as possible. This is done so that only a minimum of contaminated suture material has to be pulled through the tissue. Grasp the knotted end of the suture and pull it toward the incision line. Place the removed suture on the bracket table and use the same technique to remove the remaining sutures. Make sure you have accounted for all the sutures listed on the SF 603.
7. Use the mouth mirror to examine the surgical site and ensure that no suture material or debris remains in the tissue.
8. Place a 2 × 2 inch gauze pad over the incision site, and direct the patient to bite down on the pad, this will control any secondary hemorrhage. Advise the patient that it should be left in place for 15 minutes, or until the small amount of bleeding stops.

MAINTAINING AND PREPARING THE SURGICAL AIR DRILL

The surgical air drill in figure 5-2 is an example of a high-speed instrument commonly used in the oral surgery department. The dental officer



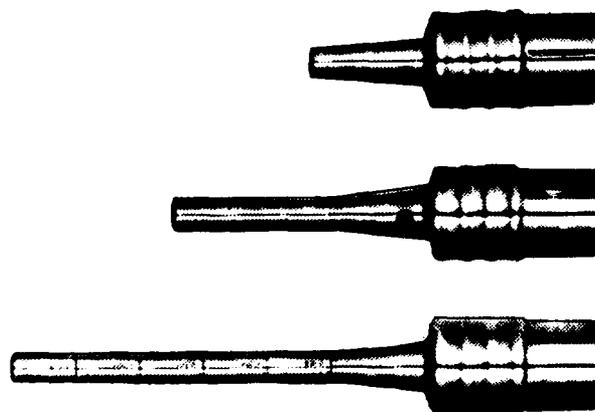
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Figure 5-2.—Surgical air drill.

uses the drill to remove bone during the extraction of impacted teeth and to section teeth when it is impossible to remove them in one piece. The drill enables the dental officer to accomplish these procedures quickly, reducing trauma to oral tissues and the chance of infection.

To use the drill, you will need bur guards (figure 5-3) and burs. Bur guards are available in three lengths: medium, long, and extra long. They protect the operator and the patient from the long shaft of the burs. Always select a bur guard that matches the length of the bur desired by the dental officer.

The air drill is a very delicate and expensive instrument. You must ensure that all dental assistants assigned to the oral surgery department



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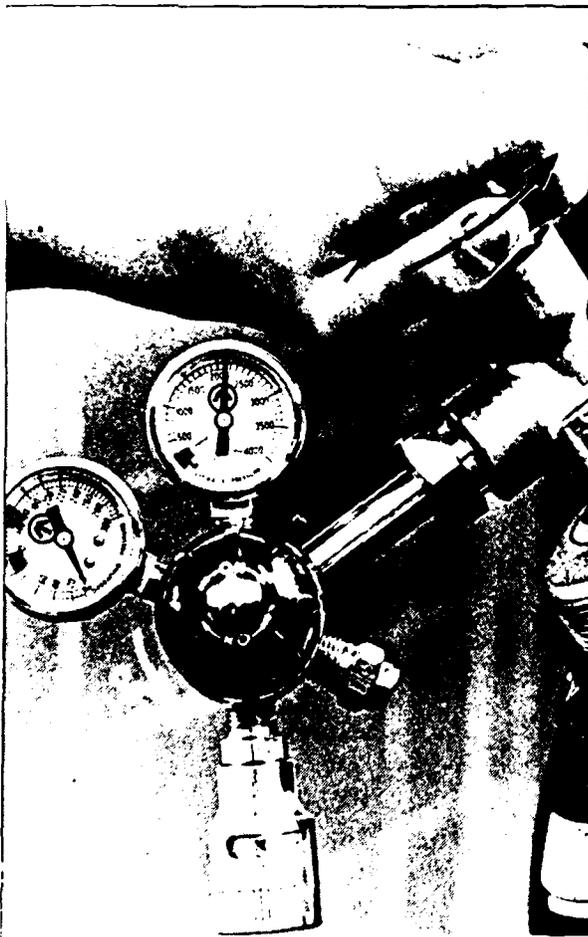
Figure 5-3.—Bur guards used with surgical air drill.

are properly trained in the maintenance of the drill and its support system.

The support system for the surgical air drill consists of a power source, a pressure regulator, and a pressure/exhaust hose.

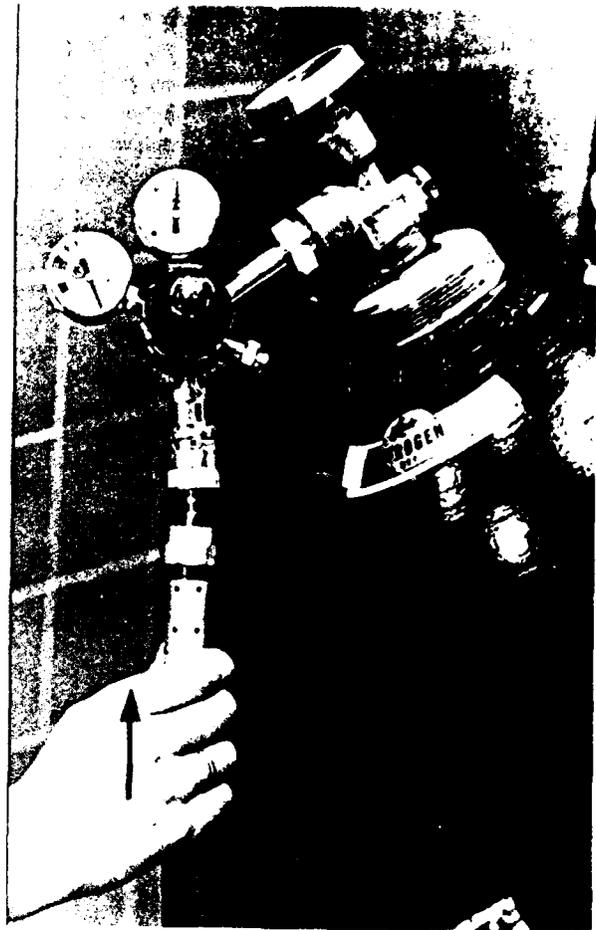
Power Source.—The recommended power source for the surgical air drill is compressed dry nitrogen. It is available in large metal storage cylinders, compressed to a pressure of 2,000 to 2,500 pounds per square inch (psi). Replace the cylinder when the pressure within it falls below 500 psi. If not replaced there may not be enough nitrogen left to complete a procedure.

Before using a new cylinder, open its top valve for a fraction of a second. This dislodges any debris that may have accumulated in the valve. Make sure the cylinder is resting securely on the floor, and that you grasp the turn valve firmly.



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Figure 5-4.—Pressure regulator attached to valve on storage cylinder. Valve is being turned on (upper right).



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Figure 5-5.—Connecting pressure/exhaust hose to pressure regulator.

WARNING: *Always point the valve aperture away from your body, because the short blast of gas or ejected debris can cause serious injury.*

Pressure Regulator.—The pressure regulator (figure 5-4) has two pressure gauges and a pressure adjustment knob. It is attached to the valve aperture on top of the storage cylinder and secured with a 1 1/8 inch wrench. The gauge on the right indicates the storage pressure within the cylinder, and the gauge on the left indicates the operating pressure. The pressure adjustment knob located at the center of the regulator is used to adjust the gas flow to the proper operating pressure.

Pressure/Exhaust Hose.—The pressure/exhaust hose connects to the pressure regulator (figure 5-5). It has a loose rubber covering through which exhaust nitrogen passes to a vent on the regulator end of the hose. An automatic shutoff

valve is located on the air drill connector end of the hose. This feature allows the dental officer to disconnect the air drill under operating pressure.

Preparation of the Surgical Air Drill

Carry out the following procedures to prepare the surgical air drill for use.

1. Direct the circulating assistant to obtain the surgical air drill pack from the CSR and place it on the Mayo stand near the patient. The pack contains a sterile air drill, bur guards, burs, and a pressure/exhaust hose.
2. Ensure that the circulating assistant wipes the nitrogen storage cylinder and its carrier with a cloth soaked in a disinfectant solution before take them into the surgical operatory. Next instruct the circulating

assistant to attach the pressure regulator to the nitrogen cylinder. Then direct the circulating assistant to slowly open the cylinder valve and verify that the pressure *within the cylinder is over 500 psi.*

3. While the circulating assistant is preparing the cylinder, don a surgical cap and mask, scrub your hands, and put on gloves and a drape. Be sure you use aseptic techniques.
4. Prepare the surgical air drill. Pick up the sterilized drill and the drill connector end of the pressure/exhaust hose (one in each hand). Align the pin on the hose fitting with the pin slot on the end of the air drill (figure 5-6). Insert the pin and turn the air drill until the pin snaps into the slot indentation. The air drill is now securely attached to the hose.

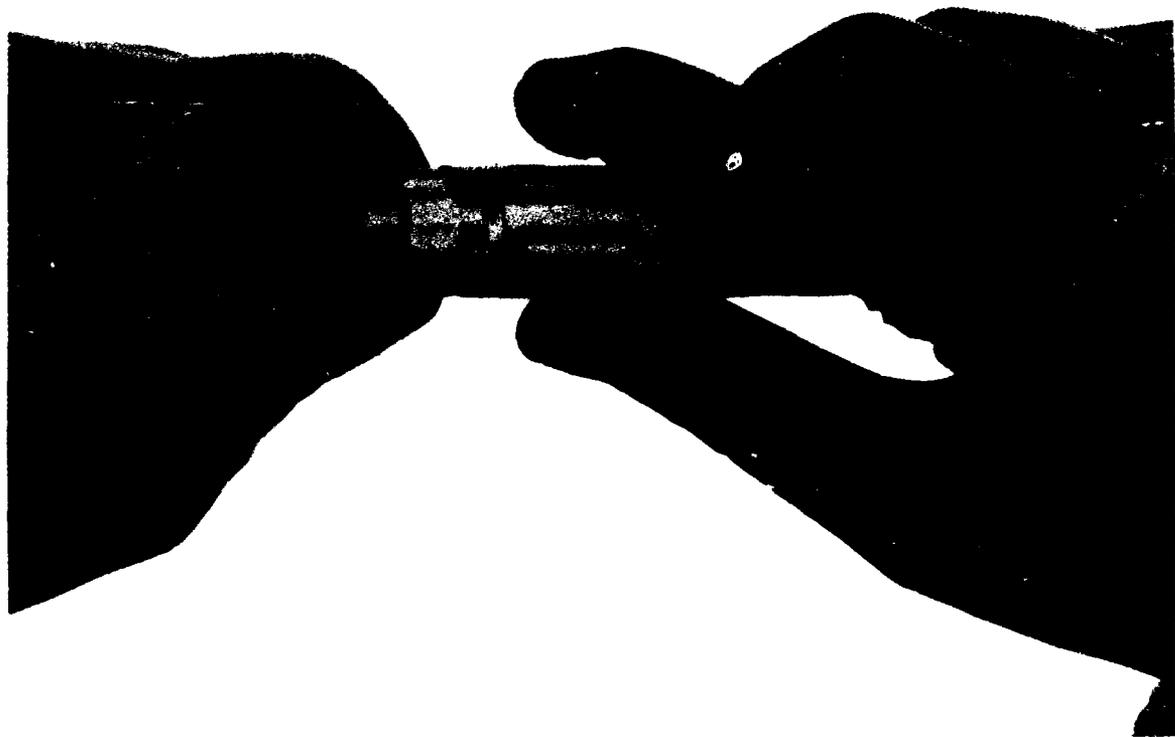


Figure 5-6.—Inserting pin on hose fitting (left) into slot on air drill (right).

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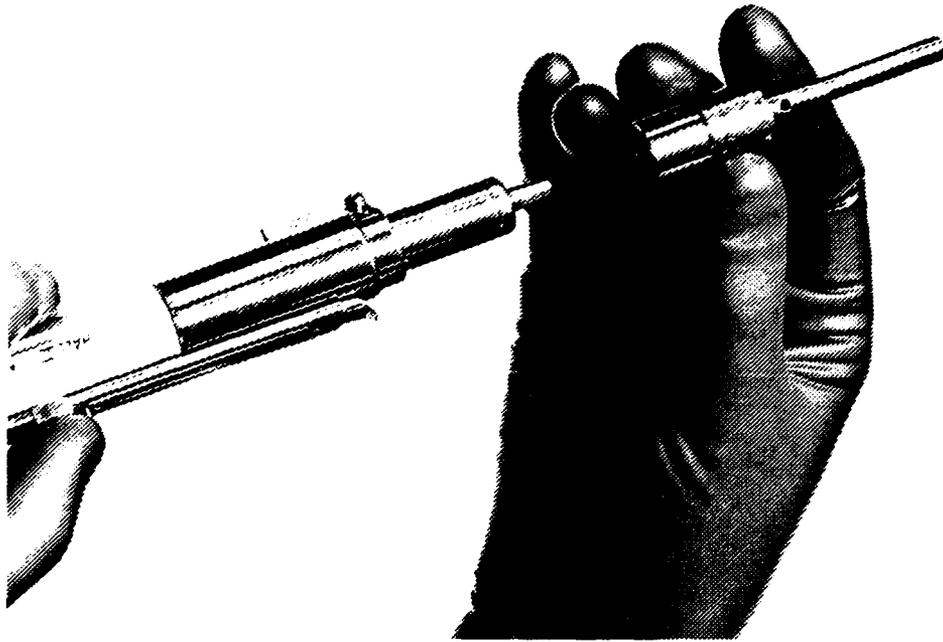


Figure 5-7.—Placing bur guard on air drill.

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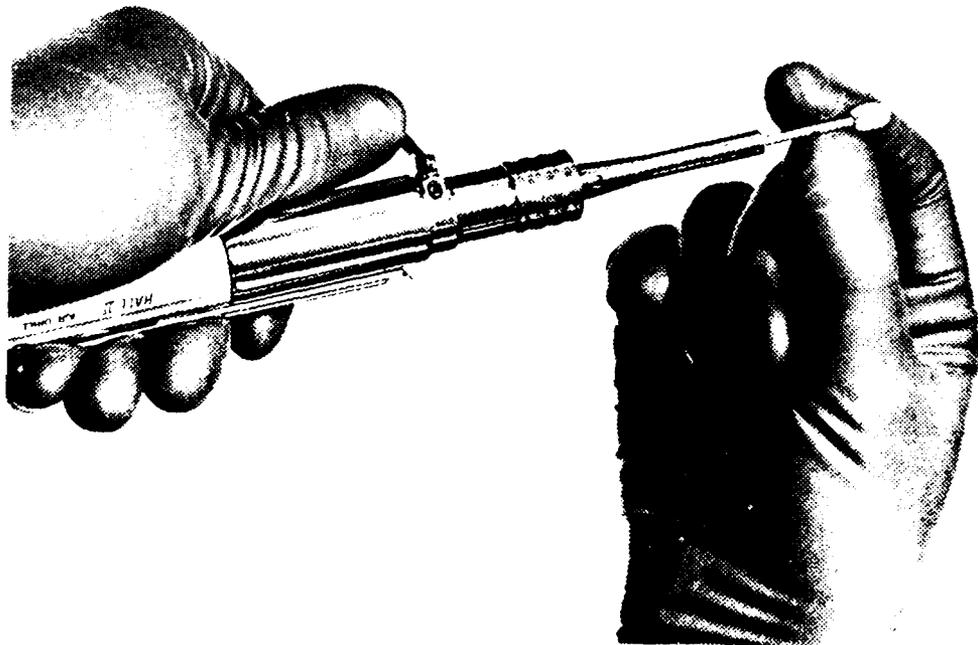


Figure 5-8.—Inserting bur into air drill.

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5. Attach the bur guard and bur to the drill. Slide the bur guard onto the drill (figure 5-7). Be sure the guard is completely seated. Push the bur release lever on the drill and insert the desired bur through the guard and into the drill (figure 5-8). Insert the bur up to the safe line ring on its shaft. Return the release lever to lock the bur in place.
6. Connect the pressure/exhaust hose and regulator. Unroll the pressure/exhaust hose and pass the regulator connector end to the circulating assistant, who should grasp only the end of the hose. The circulating assistant will then connect the hose to the pressure regulator.
7. Secure the pressure/exhaust hose and place the remainder of the hose on the patient's body drape. Clamp the hose between folds of the drape with a sterile towel clamp to prevent the hose from falling. Be sure to provide enough slack so the dental officer can operate the drill without restriction.
8. Set the operating pressure. Direct the circulating assistant to slowly turn the pressure adjustment knob clockwise until the operating pressure reaches 90 to 110 psi. The operating pressure is adjusted while the air drill is in operation to ensure that the desired pressure is reached. The air drill is now ready for operation. **NOTE:** Once the operating pressure adjustment knob is set for 90 to 110 psi, it is not necessary to readjust the knob. If the regulator and tank have been used before, operate the drill and check to ensure that the operating pressure is indeed 90 to 110 psi.

When the surgical procedure is completed, turn the nitrogen cylinder valve off. The storage pressure gauge should indicate zero. Let the air drill run until the operating pressure gauge indicates zero psi. This bleeds all the nitrogen from the pressure/exhaust hose and regulator. When both regulator gauges indicate zero psi, disconnect the pressure/exhaust hose from the regulator.

Cleaning the Surgical Air Drill

Once the surgical procedure is completed and the patient has been dismissed, move the drill and support equipment to the cleaning and processing area. Do not allow blood or oral fluids to dry on the equipment, because they are difficult to remove.

To prevent the drill from being damaged during cleaning, **DO NOT** immerse it in any solution. Always hold the bur end of the drill at a downward angle while cleaning it. **DO NOT** allow water or cleaning solutions to enter the collet or get inside the drill, because this can damage the internal parts of the instrument. (A good practice is to leave the pressure/exhaust hose attached to the drill while cleaning. This will help prevent fluids from entering the drill.) Following are specific cleaning procedures for the surgical air drill.

1. Clean the drill's external surface, remove the bur and the bur guard and thoroughly scrub the drill with a soft brush and mild detergent. Several commercial detergents are available for cleaning the drill. Use them according to the manufacturer's instructions. Remove all traces of blood and debris. After scrubbing, rinse off all traces of detergent under running tap water. To prevent discoloration from the tap water, flush the surface of the drill with distilled water. Dry the air drill with a clean, lint-free towel.
2. Clean the bur guard. Scrub the bur guard with a soap and water solution. If necessary, use a small bottle brush to clean the inside. To clean the tip of the guard, pass a pipe cleaner through the small opening.
3. Lubricate the drill and bur guard. Once the drill and bur guard are clean, place two drops of the manufacturer's lubricant into the inlet on the hose connector end of the drill. Place one drop of lubricant on the tip of the bur guard. Connect the lubricated drill and pressure/exhaust hose to the nitrogen cylinder. Run the drill for 30 to 60 seconds at full speed under an operating pressure of 90 to 110 psi to carry the lubricant into the drill. Disconnect the air drill and hose. **NOTE:** These drill lubrication procedures apply to the drill shown in figure 5-2. Newer surgical air drills have sealed bearings and therefore do not require lubrication. Be sure to check the manufacturer's instructions before lubricating the drill. Bur guards are always lubricated.
4. Clean the pressure/exhaust hose. Wipe it with a cloth dipped in a soap and water solution. Then wipe it with a damp, lint-free cloth to remove soap residue.

5. Clean the surgical bur. If the bur used in the surgical procedure is still usable, scrub it with soap and water. Use a bur brush to remove all debris from the bur's cutting end.

Sterilization of the Surgical Air Drill

The surgical air drill and its accessories may be sterilized in a gas sterilizer or an autoclave. If a gas sterilizer is used, follow the manufacturer's sterilization procedures. To autoclave the materials, carry out the following procedures.

NOTE: DO NOT autoclave the pressure regulator.

1. Place the air drill, bur guards, burs, and pressure/exhaust hose in the stainless steel sterilization case. The case is perforated to allow entry of steam under pressure. Place the air drill in the center of the case. Then coil the hose and place it over the drill. Place the bur guard on its holder. Insert all burs in the wire coil on the inside cover of the sterilization case.
2. Close the case and wrap it in two double-thickness muslin wraps, following the pack-wrapping procedures outlined in *Dental Assistant, Basic*. Ensure that the top of the sterilization case faces upward when the wraps are opened.
3. Sterilize the pack according to the manufacturer's recommendations.

WARNING: *Do not use the air drill for a surgical procedure until it has cooled to room temperature. If the instrument is still warm when the pack is opened, you may operate it briefly to cool it. The dry nitrogen will cool only a warm drill, not a hot one.*

EMERGENCY EQUIPMENT AND MATERIALS

Oral surgery operatories are normally equipped with emergency lifesaving equipment and materials. Such items include; oxygen resuscitation equipment, oropharyngeal airway instruments, intravenous solutions and medications, and other items as directed by the dental officer. Figure 5-9 is a list of items recommended for emergency use.

NOTE: Some of the items are considered as Schedule III material under the Comprehensive

Drug Abuse Prevention and Control Act of 1970 (e.g., syringes, needles, medications). You must therefore maintain proper security for them.

Maintain a contents checklist in the emergency kit (or cart). Periodically inventory the equipment and materials to ensure that adequate supplies of all required materials are present. Also check all medications and solutions to ensure that expiration dates have not passed.

Because oxygen resuscitative equipment varies from one facility to another, only general handling precautions are discussed below. You must become familiar with the equipment at your facility.

Use and Storage of Oxygen

Before using an oxygen cylinder, open the top valve for a fraction of a second to dislodge any debris that may be present. Ensure that the cylinder is resting securely on the floor and that you grasp the turn valve firmly.

WARNING: *Always point the valve aperture away from your body, because the short blast of gas or ejected debris can cause serious injury.*

Observe the following precautions concerning oxygen use and storage:

- **DO NOT** use oxygen fittings, valves, regulators, or gauges with any other gas.
- **DO NOT** use oxygen unless it is channeled through a pressure-reducing regulator.
- **DO NOT** use regulators that need repair or cylinders with faulty valves.
- **DO NOT** use oxygen in the presence of an open flame.
- **DO NOT** place oxygen equipment near heating equipment, dry heat sterilizers, or autoclaves.
- **DO NOT** permit grease, oil, or combustible materials to come in contact with oxygen equipment.
- **DO NOT** use ungrounded electrical equipment in spaces where oxygen is used or stored.

RECOMMENDED LIST OF EMERGENCY SUPPLIES

		Quantity
1.	6515-00-018-9494 Resuscitator, Hand Operated, Intermittent Positive Pressure	1
2.	6515-00-753-4881 Mask, Oronasal (Resuscitator and Anesthesia, Small Adult)	1
3.	6515-00-299-8297 Mask, Oronasal (Resuscitator and Anesthesia, Large Adult)	1
4.	Oxygen Tank (E), Flow Gage, and Wrench	
5.	4720-00-141-9058 Tubing, Rubber (from O ₂ tank to resuscitator)	1
6.	6515-00-371-3100 Sphygmomanometer, Nonconductive	1
7.	6515-00-374-2220 Stethoscope	1
8.	6515-00-462-7348 Syringe, Hypodermic, Disposable, 3 ml	6
9.	6515-00-754-0406 Syringe, Hypodermic, Disposable, 5 ml	4
10.	6515-00-754-0412 Syringe, Hypodermic, Disposable, 10 ml	4
11.	6515-00-754-2834 Needle, Hypodermic, Disposable, 18 gage, 1½"	6
12.	6515-00-754-2838 Needle, Hypodermic, Disposable, 21 gage, 1¼"	6
13.	6515-00-655-5751 Needle, Hypodermic, Disposable, 25 gage, 5/8"	4
14.	6515-00-089-2791 Intravenous Injection Set, 21 gage Needle, Pediatric, Dispos.	4
15.	6515-00-117-9021 Intravenous Injection Set, with Flexible Drip Chamber, 20 gage Needle, Disposable	2
16.	6515-00-889-7448 Intravenous Injection Set, 18 gage Needle, Disposable, Field	2
17.	6515-00-959-8116 Tube, Connecting, Syringe and Needle, Plastic, Disposable Two Screw-Type Shut-Off Clamps, 30 inch (For use in administering intravenous solutions)	2
18.	6515-00-383-0565 Tourniquet, Nonpneumatic, 1½ by 42 inches	1
19.	6515-00-324-5500 Depressor, Tongue, Wood	
20.	6515-00-310-2200 Block, Bite, Rubber or Nylon, Jackson, Adult	2
21.	6515-00-385-1100 Cannula, Laryngeal, Jackson, Aspirating Tube	1
22.	6515-00-616-5052 Laryngoscope, Infant-Child-Adult, MacIntosh	1
23.	6515-00-817-1206 Tube, Endotracheal, Magill, 4 mm, 18 cm long	1
24.	6515-00-961-5520 Tube, Endotracheal, Magill, 7 mm, 30 cm long	1
25.	Cricothyroidotomy Set (Needle and Adapters)	1
26.	6515-00-332-3300 Forceps, Endotracheal Tube, Magill	1
27.	6515-00-334-3800 Forceps, Hemostatic, Curved, Kelly	1
28.	6515-00-333-2400 Forceps, Dressing, Bayonet Shaped	1
29.	6515-00-299-8748 Airway, Pharyngeal, Rubber, Child	1
30.	6515-00-300-2900 Airway, Pharyngeal, Rubber, Large Adult	1
31.	6515-00-300-2910 Airway, Pharyngeal, Rubber, Small Adult	1
DRUGS		
32.	6505-00-209-3760 Epinephrine Injection, 1:1000, 1 ml	
33.	6505-00-754-2547 Atropine Sulfate Injection, USP, 0.4 mg per ml, 20 ml	
34.	Mephentermine Sulfate (Wyamine), 15 mg per ml	
35.	Benadryl Hydrochloride, 50 mg per ml	
36.	6505-00-137-5891 Diazepam Inj., USP, 5 mg per ml, Syringe-Needle Unit, 2 ml (Ideally, the above five medications should be in therapeutic size ampules X2 and suitable for I.M. or subcutaneous injection, rather than I.V.)	
37.	6505-00-116-4600 Dextrose Injection, USP, 5%, 1000 ml	1
38.	6505-00-299-8615 Ringer's Injection, Lactated, 1000 ml	1
39.	6505-00-619-8620 Nitroglycerin Tablets, 0.6 mg (1/100 gr) (For use in managing angina pectoris patients)	

Figure 5-9.—Emergency supplies for oral surgery operatories.

- Post "Oxygen No Smoking" signs at the entrance to, and on the walls of all spaces where oxygen is used or stored.
- Store oxygen only in spaces specifically designated for compressed gases. Large oxygen cylinders must be stored upright and chained to prevent them from falling over.

ENDODONTICS

Endodontics is the dental specialty concerned with diseases and injuries of the dental pulp and periapical tissues. Your primary duty in endodontics is to assist the dental officer. You may, however, be directed to perform certain procedures under the dental officer's supervision.

The specific type of treatment the dental officer renders depends upon the pulp's condition. If the pulp cannot be returned to normal, the dental officer will perform a root canal. After the dental officer removes the pulp tissue, you will schedule a series of appointments for the patient. During these appointments you may be directed to carry out the following procedures:

- Remove a temporary seal.
- Take samples for a bacteriologic culture.
- Irrigate the root canal(s).
- Place a temporary seal.

In carrying out these procedures, maintain an aseptic technique at all times. All instruments used in endodontic procedures must be sterile. If an instrument becomes contaminated, place its operating end into a glass bead sterilizer (figure 5-10) for 10 seconds. When running properly, this sterilizer reaches a temperature of 450°F (232°C).

Before performing any endodontic treatment, place a rubber dam to isolate the teeth indicated by the dental officer. Then disinfect the operating site as described in *Dental Assistant, Basic*.

TEMPORARY SEAL REMOVAL

A temporary seal usually consists of an outer layer of zinc oxide-eugenol (or other temporary restorative material) and an inner layer of gutta-percha. A small, medicated cotton pellet is located below the gutta-percha.

To remove a temporary seal, remove the temporary restorative material, the gutta-percha, and the cotton pellet with a sterile spoon excavator. When removing the medicated pellet, be sure to avoid compressing it into the tooth apex.

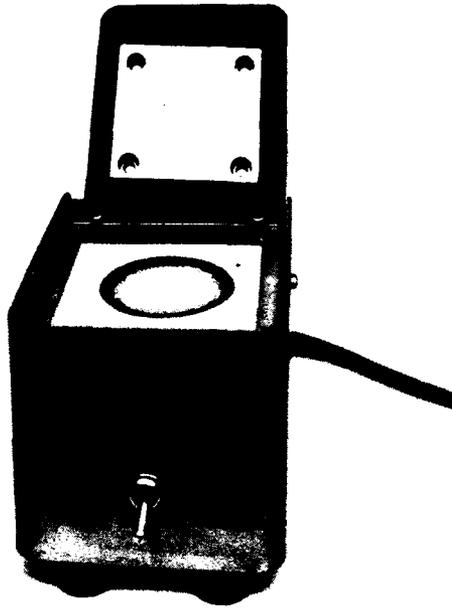
BACTERIOLOGIC CULTURING

After the temporary seal has been removed, the dental officer may direct you to take a sample from the canal for a bacteriologic culture. Culturing is a technique used to determine the presence of microorganisms in the root canal. A negative culture reading usually indicates the absence of microorganisms in the canal; a positive reading usually indicates the presence of microorganisms.

A common culturing method involves the use of paper points, cotton forceps, and a test tube containing a culture medium. All instruments and materials used in the culturing procedure must be sterile. This ensures an accurate culture reading.

When taking a sample for culturing, follow these steps:

1. Review box 17 of the patient's SF 603 for any entry indicating the working distance, the reference point, and the size of the last instrument used in the canal. If this information is not recorded, ask the dental officer for instructions.
2. Select a sterile paper point that closely matches the size of the last instrument used in the root canal. Using sterile cotton forceps, carefully insert the paper point into the canal to a depth 1 mm short of the working distance. Once in position, rotate the point so that it makes contact with the canal's entire interior surface. Leave it in position for 1 minute.
3. Remove the test tube cap without contaminating the sterile inner lip of the tube. Use the cotton forceps to remove the paper point from the canal and drop it into the test tube. If a multirouted tooth is being treated, take a sample from each canal. Use separate paper points for each canal, but place them all in one test tube.
4. Replace the test tube cap. The paper point(s) should be immersed in the culture medium. If not, tilt the tube slightly. Once the paper point makes contact with the culture medium, it will sink to the bottom of the tube.



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Figure 5-10.—Glass bead sterilizer.

When you have completed these steps, put the test tube in an incubator. Leave the test tube in the incubator for a minimum of 48 hours at normal body temperature of 98.6°F (37°C). After 48 hours, the dental officer will check the test tube. If the culture is clear, the canal should be free of bacteria. If the medium is cloudy, there is bacteria in the canal and appropriate treatment is initiated. In either case, record the results of the culture in box 17 of the patient's SF 603.

ROOT CANAL IRRIGATION

After the dental officer treats the root canal, you may be directed to irrigate it. The most commonly used sterile irrigating solutions are 2.5% to 5% sodium hypochlorite, a 3% hydrogen peroxide solution, and urea peroxide. To irrigate the root canal; obtain the following:

- A sterile disposable irrigating syringe with a 22- or 23-gauge blunt needle.
- A saliva ejector hose with another 22- or 23-gauge blunt needle (instead of a disposable plastic tip).
- The designated irrigating solution.
- Sterile cotton forceps.

- Sterile paper points.

To irrigate the root canal, follow these steps:

1. Review box 17 of the patient's SF 603 for the working distance of the tooth being treated. If it is not recorded, ask the dental officer for instructions.
2. Prepare the instruments and materials and place them on the bracket table. Load the syringe with the prescribed irrigating solution. Remove all fluids from the operating site with the saliva ejector.
3. Insert the needle of the irrigating syringe into the canal to a depth 4 mm short of the working distance. **DO NOT** force the needle into the canal. If you feel resistance, slightly withdraw the needle. Gently irrigate the canal. **NEVER** use force. Forcing the solution into the canal may cause it to be expressed through the tooth apex into the periapical tissue.
4. Once the canal is irrigated, dry it with the saliva ejector and sterile paper points. Hold the tip of the saliva ejector near the canal opening and withdraw the excess irrigating solution. Then dry the canal with paper points measured to the working distance.

TEMPORARY SEAL PLACEMENT

After irrigating the canal, you may be directed to medicate and reseal it. To do this, perform the following procedures:

1. Select a small sterile cotton pellet that will fit into the pulp chamber and allow sufficient space for a two-layer seal.
2. Hold the pellet with the sterile cotton forceps and place one drop of the designated medication on the pellet. Squeeze excess medication from the pellet with a sterile 2 × 2 inch gauze pad. Insert the medicated pellet into the pulp chamber with the forceps.
3. Attach a small ball of gutta-percha to the blade end of a plastic filling instrument. Soften the gutta-percha by passing the blade of the instrument through an open flame.
4. Place the softened gutta-percha into the pulp canal chamber, directly over the cotton pellet. Gently compress it into a smooth layer with the filling instrument. Be sure to leave about 2 mm of the access cavity

unfilled. This allows room for the outer seal. Remove any gutta-percha that adheres to the access cavity margins.

5. To complete the procedure, place a thick mix of zinc oxide-eugenol cement (or other temporary restorative material designated by the dental officer) over the inner gutta-percha seal. Be sure to check the patient's occlusion. It is extremely important that the treated tooth not be traumatized by occlusal prematurity.

PERIODONTICS

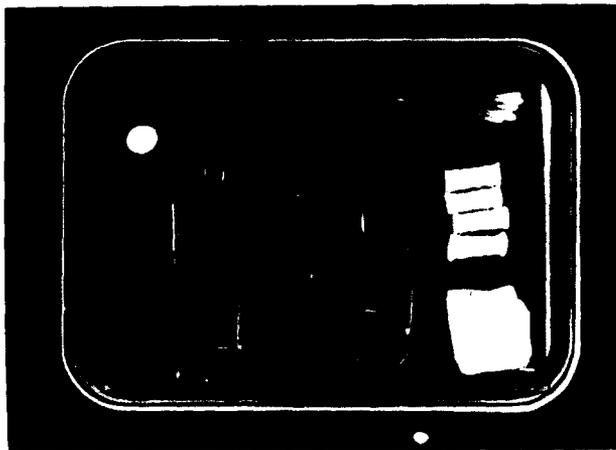
Periodontics is the dental specialty concerned with the prevention, diagnosis, and treatment of diseases affecting the supporting tissues of the teeth. These tissues, collectively called the periodontium, include the gingiva, cementum, periodontal ligament, and the alveolar bone.

Basic dental assisting tasks performed in the periodontics operatory are outlined in *Dental Assistant, Basic*. You may want to review that material before studying this section.

This section covers the advanced tasks you may be required to perform in the periodontics operatory. Such tasks include removing periodontal dressings when sutures are not present, and sharpening periodontal instruments.

PERIODONTAL DRESSING REMOVAL

A periodontal dressing is a surgical dressing placed over a periodontal surgical site. It is kept in place for 5 to 7 days following surgery. It



278.119

Figure 5-11.—Setup for removing a periodontal dressing.

protects the underlying surgical site from trauma during mastication, helps maintain tissue and suture position, and helps maintain homeostasis by acting as a compress over the site. The dressing also acts as a splint.

The dental officer removes the periodontal dressing at the first postoperative visit. If a second dressing is placed, you may be instructed to remove it. Figure 5-11 shows the instruments and materials needed to remove the dressing. To remove a periodontal dressing:

1. Check the patient's SF 603 to determine if sutures were placed. If sutures are present, the dental officer will remove the dressing.
2. Place a sterile towel on the bracket table, then place all needed instruments and materials on the towel. Adjust the dental chair so the patient is comfortable. Turn on and adjust the dental operating light.
3. Wash your hands and put on sterile gloves.
4. Remove the dressing by inserting a scaler tip beneath the lower edge of the periodontal dressing. Exert gentle upward pressure to separate the dressing from the tissue and break it into pieces.
5. With a curette and cotton forceps, remove any remaining dressing material from the tooth surfaces and the interproximal spaces. Ensure that all dressing material is removed. Foreign particles can cause irritation and affect the healing of the surgical site.

After all dressing material is removed, moisten a cotton-tipped applicator with sterile saline solution. Use the applicator to gently remove all material alba (white film) from the healing tissue. If plaque is present on the teeth in the surgical area, carefully remove it with the curette. Once this is done have the patient gently rinse with warm water. Ask the dental officer to inspect and approve your work.

INSTRUMENT SHARPENING

As an advanced dental assistant in the periodontics operatory, you are responsible for keeping instruments sharp. A dull instrument is less effective and can cause unnecessary trauma to the patient. Check all instruments for sharpness immediately after they are scrubbed, if dull sharpen them before they are sterilized.

Recognizing when instruments are dull is the key to your success in maintaining sharp instruments. To determine sharpness or dullness, you must be familiar with each instruments

cutting edge(s). Remember, a cutting edge is formed by the intersection of two surfaces of the instrument's blade.

Under good lighting, examine a cutting edge for sharpness using a magnifying glass or by looking directly at it while slightly turning the instrument. A dull edge reflects light and creates a glare because the edge has been rounded off by use. A sharp cutting edge will not reflect light and appears as a line.

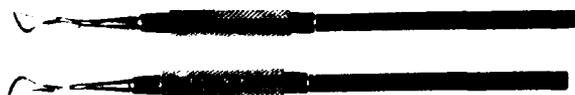
Sharpening Devices

The correct sharpening device is critical for a good cutting edge. Hard felt wheels are recommended for periodontal knives, sharpening stones for curettes, chisels, and scalers.

Sharpening stones are available in various grits (textures) and designs to meet particular needs. The Ruby and Arkansas stones are the most commonly used. The Ruby stone is fairly coarse, cuts rapidly, and is used primarily for initial sharpening of very dull instruments. The Arkansas stone is fine in texture and can be used alone to attain a satisfactory edge.

Depending on their design and method of use, sharpening stones are either mounted or unmounted. Some are mounted on a mandrel for insertion into the dental handpiece. Others are mounted on mechanical devices and are known as mechanical sharpeners. Unmounted stones may be rectangular, cylindrical, or specially shaped. These stones are often lubricated with water or oil to avoid clogging with metal particles as they grind the instruments.

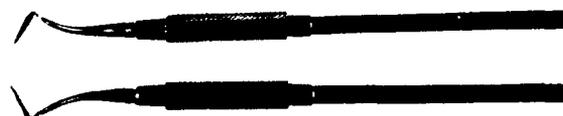
No matter what device is used, sharpen instruments by grinding or polishing the surfaces that form the cutting edges. How often they need sharpening depends on the amount of use and the method of sterilization. After frequent sharpening an instrument can become greatly reduced in size discard it. Rather than risk the chance of breakage



Photograph Courtesy of Hu-Friedy

278.136X

Figure 5-12.—Kirkland periodontal knives: No. 16 (top) and No. 15 (bottom).



Photograph Courtesy of Hu-Friedy

278.137X

Figure 5-13.—Orban periodontal knives: No. 1 (top) and No. 2 (bottom).



Photograph Courtesy of Hu-Friedy

278.138X

Figure 5-14.—Kirkland knife cutting edges: inner (1), outer (2), and back (3).

during a procedure. Keep in mind that the amount of metal ground away on mounted stones is greater than that removed on unmounted ones.

Periodontal Knife Sharpening

The periodontal knives most commonly used are the No. 15 and No. 16 Kirkland knives (figure 5-12) and the No. 1 and No. 2 Orban knives (figure 5-13). Both types are sharpened with a hard felt wheel mounted on a dental lathe. **DO NOT** attempt to sharpen them on a stone. It is too difficult to maintain their functional shape and blade bevel when a sharpening stone is used.

Kirkland knives have three cutting edges to sharpen, the inner and outer, and the back edge (figure 5-14). The Orban knives have two cutting



Photograph Courtesy of Hu-Friedy

278.139X

Figure 5-15.—Orban knife cutting edges: inner (1) and outer (2).

edges, the inner and outer edges (figure 5-15). Apply an abrasive, such as chrome rouge, to the felt wheel to aid in the sharpening process. Sharpen both sides of each edge by following these steps:

1. Hold the knife handle between your thumbs and forefingers (both hands). Stabilize your hands or elbows on the work bench.
2. Hold the knife so that the felt wheel rotates away from the cutting edge (figure 5-16).



Photograph Courtesy of Hu-Friedy

278.140X

Figure 5-16.—Felt wheel rotating away from cutting edge of knife.

3. Place the knife against the wheel at an angle conforming to the bevel of the blade. Gently apply the knife to the wheel. Sharpen both sides of all cutting edges and check each edge for sharpness.

Periodontal Curette Sharpening

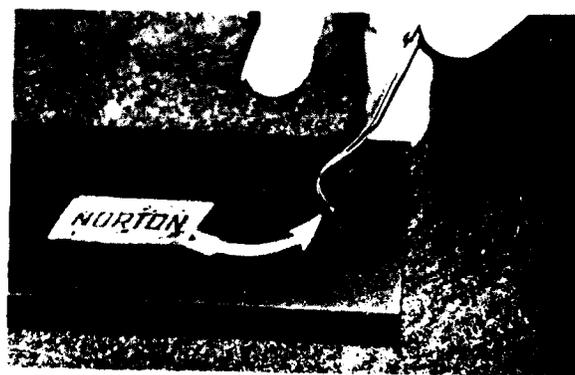
Curettes are the most commonly used scaling instruments. Universal curettes (McCall curettes) have two cutting edges and are sharpened on both sides. Gracy curettes are sharpened only on the outer curve. Both, however, have a rounded tip that must be maintained during sharpening.

When using a stationary stone, hold the curette in a modified pen grasp and establish a finger rest at the edge of the stone (figure 5-17). Draw the side of the blade toward you. Because the curette is curved, you must repeat this process until the entire arc of the cutting edge is sharpened. Be sure to lubricate the stone during the sharpening procedure.

When sharpening a curette on a mounted stone, be sure the wheel rotates away from the side of the blade, as shown in figure 5-18.

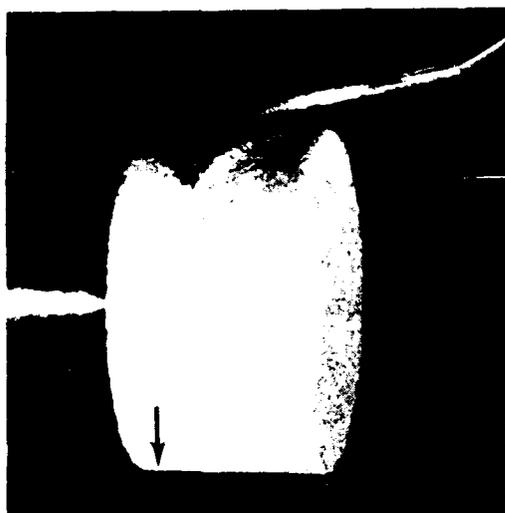
Periodontal Chisel Sharpening

The No. 1 and No. 2 Ochsensbein chisels (figure 5-19) are the most commonly used periodontal chisels. They have three cutting edges, a flat edge on the tip and a curved edge on each side of the tip. Figure 5-20 shows the head of the No. 2 Ochsensbein chisel. Notice that the edges to be sharpened are up, toward you, on the convex side of the chisel head. But the cutting edges on the No. 1 Ochsensbein are reversed, they are on

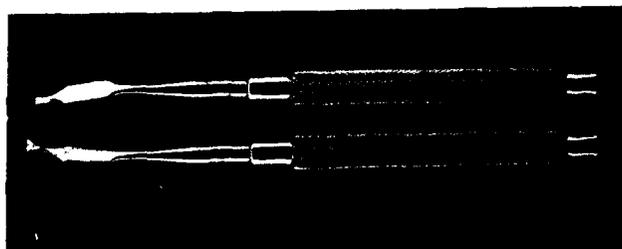


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Figure 5-17.—Sharpening curet on stationery sharpening stone.



278.142
Figure 5-18.—Mounted stone rotating away from side of curet blade.

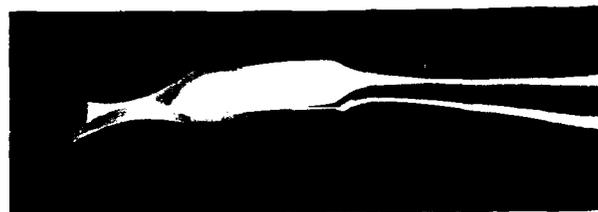


278.143X
Figure 5-19.—Ochsensbein periodontal chisels: No. 2 (top) and No. 1 (bottom).

the concave side of the head. (Another commonly used chisel, the TGO chisel, is a smaller version of the Ochsensbein chisel. It is also sharpened as described below.)

Follow these steps to sharpen a periodontal chisel:

1. Use a flat Arkansas stone to sharpen the edge on the chisel tip. Position the blade on the stone at an angle conforming to the bevel of the blade. Then push the blade across the stone toward the cutting edge.
2. Use a cylindrical sharpening stone or one with rounded edges to sharpen the curved edges on the sides of the chisel head. Position the stone on the blade at an angle conforming to the bevel of the blade. Twist or rotate the stone until the edge is sharp.



Photograph Courtesy of Hu-Friedy

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Figure 5-20.—Tip of Ochsensbein No. 2 chisel with cutting edges on convex side of blade.

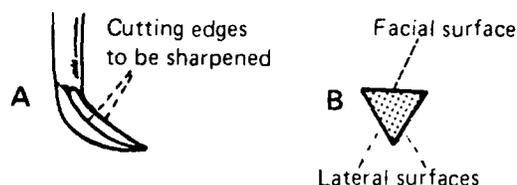


Figure 5-21.—Tip of sickle scaler (A); cross section of tip (B).

DO NOT draw the sharpening stone over the cutting edge.

Scaler Sharpening

Sickles and hoes are commonly used scaling instruments. Sickle scalers have two cutting edges, which form a point where the facial and lateral surfaces meet (figure 5-21). Sharpen the sickle scaler by grinding the facial and lateral surfaces on a stationary stone. Be careful to maintain the sharp point of the sickle.

To sharpen the facial surface, hold it flat against the side of the stone, as shown in figure 5-22, and draw the instrument back and forth.

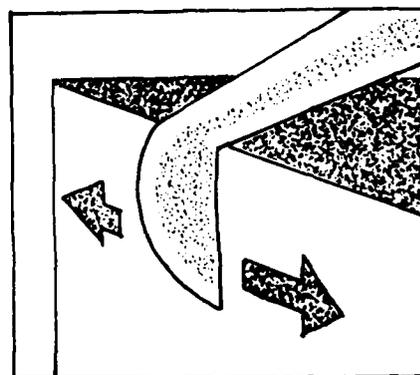


Figure 5-22.—Sharpening facial surface of sickle scaler.

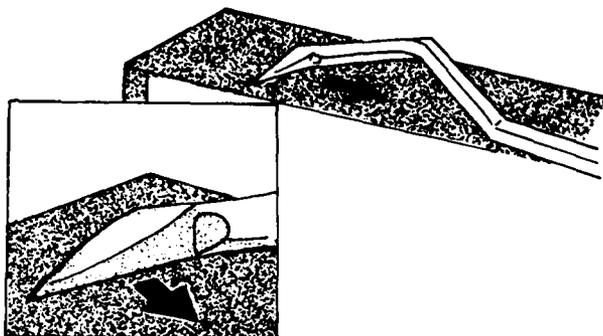


Figure 5-23.—Sharpening lateral surface of sickle scaler.

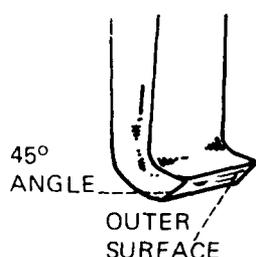


Figure 5-24.—Hoe scaler.

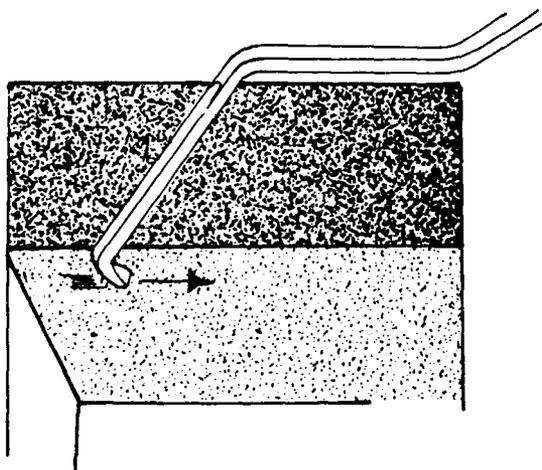


Figure 5-25.—Sharpening hoe scaler.

To sharpen a lateral surface, position the surface against the stone. Then draw the instrument across the stone toward the cutting edge (figure 5-23). Repeat until the edge is sharp and then do the same with the other lateral surface.

A hoe scaler has only one edge. Sharpen this instrument by grinding only the outer surface of the cutting edge (figure 5-24). The outer and inner blade surfaces form a 45° angle, so you must maintain this angle against the stone. Draw the instrument across the stone toward the cutting edge, as shown in figure 5-25. Repeat as often as necessary to obtain a sharp edge.

SUMMARY

When directed, you may perform certain expanded tasks in the endodontics, periodontics, and oral surgery operatories. These procedures always require the use of aseptic techniques. Whether performing POT, taking samples for a bacteriologic culture, or removing a periodontal dressing, take all necessary precautions to lessen the possibility of infection or contamination. The tasks may change, but the importance of asepsis is constant.

Your duties within the oral surgery operatory may include treating alveolar osteitis, removing sutures, and maintaining emergency equipment and supplies. Treatment of alveolar osteitis consists of irrigating the extraction site and placing medicated iodoform gauze in the tooth socket. Removing surgical sutures, though not a very difficult procedure, requires your utmost attention. Be sure to cut the sutures as close to the tissue as possible, and ensure that your count is the same as that on the SF 603. When maintaining emergency equipment and supplies, ensure their security and safe handling. Periodically inventory them and check for the passing of expiration dates where appropriate.

Removing and placing a temporary seal, irrigating a root canal, and taking samples for a bacteriologic culture are procedures you may perform in the endodontics operatory. Ensure that all instruments are sterile and disinfect the operating site before treatment.

In the periodontics operatory you are responsible for keeping instruments sharp. Become familiar with the instruments and learn to recognize a dull cutting edge. Use a hard felt wheel to sharpen periodontal knives, and sharpening stones for curettes, chisels, and scalers.

CHAPTER 6

PROSTHODONTICS

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify dental materials used in prosthodontic procedures.
2. Identify prosthodontic equipment and recognize safety and user-maintenance requirements.
3. Recognize procedures for making diagnostic impressions and casts.
4. Recognize procedures for fabricating custom trays.
5. Recognize procedures for preparing and cementing temporary crowns.
6. Recognize procedures for fabricating bite guards.
7. Recognize procedures for repairing complete and removable partial dentures.

Prosthodontics is the branch of dentistry concerned with the replacement of missing teeth and oral structures by artificial devices. These devices are known as prostheses or prosthetic appliances.

As a basic dental assistant, you assisted the dental officer in preparing and inserting crowns, complete and removable partial dentures, and fixed partial dentures. As an advanced dental assistant, you may perform certain expanded functions in the prosthodontic operator. Preparing and cementing temporary crowns and making diagnostic impressions and casts should be within your capabilities. Depending on your facility's staffing, you may also be required to make bite guards, custom trays, and denture repairs.

MATERIALS

Many dental materials are unique to prosthodontic procedures. You must know these items; i.e., the way they must be handled, how they will react, and how they should be stored. This knowledge is necessary not only for successful performance, but also to avoid repeating a failure. Failure means physical discomfort for the patient and additional clinic time.

IMPRESSION MATERIAL

A variety of impressions are made in the prosthodontic operator. Each requires a material of

slightly different properties. The dental officer determines which material best meets the requirements of each case. The two commonly used impression materials are alginate hydrocolloid and polysulfide rubber.

Alginate Hydrocolloid

Commonly called alginate, this impression material is an elastic material that gels by chemical action. It is supplied in powdered form, either in bulk or in measured portions packaged in foil envelopes. It is used to make preliminary impressions for diagnostic casts and final impressions for removable partial dentures.

The powder must be stored in a cool place. In bulk form, it must be kept in a tightly closed container to protect it from contamination and prevent it from absorbing moisture. Because the alginate is highly susceptible to drying, you should pour the cast within 10 minutes after taking the impression.

Polysulfide Rubber

An elastic type material (commonly called rubber base), polysulfide rubber is supplied as a two-part system: a base and a catalyst. In Navy dentistry, the two-part system is most commonly used. It does not require special storage but does

require careful handling. The stains it produces on contact with clothing are almost impossible to remove.

Rubber base material is normally used for fixed prosthetic units (crowns, bridges), but it can also be used for removable partial and complete denture impressions. You should pour casts within 30 minutes after the impression is made.

CAST MATERIALS

Cast materials (gypsum products) are powders that become hard and rigid when mixed with water. The most common is dental plaster, also known as plaster of paris. Dental stone (hydrocal) is much harder than plaster and is used mainly for master casts in complete and partial denture construction. Dental stone is colored by the manufacturer to distinguish it from plaster.

You must always be aware of the many factors involved in the mixing and setting of dental plaster and stones. For instance, the water-powder ratio affects the setting time of the materials. The more water you use, the longer the setting time. Too much water may significantly affect the material's strength. You should, therefore, follow the manufacturer's recommendations for mixing dental plasters and stones.

Water temperature and spatulation (stirring) time and speed may also affect the setting and strength of gypsum products. Normally, the colder the water, the longer the setting time. Conversely, warm or hot water speeds up the setting time. The longer or faster the mixture is stirred, the shorter the setting time.

Dental plasters and stones are sensitive to humidity changes. They readily absorb water from the air. Consequently, they must be stored in airtight, moisture-proof containers.

DENTAL WAXES

Although other types of waxes are used in dentistry, you need to be familiar with only three: sticky wax, utility wax, and baseplate wax.

Sticky wax is a hard, tacky wax with a high resin content. The resin gives the wax its adhesiveness. It is excellent for joining the parts of a broken denture for repair.

Utility wax is extremely pliable and is marketed in rope form. Somewhat tacky at room temperature, it is usable without heating. It is used to build up impression tray borders.

Baseplate wax is used to create a space on a custom tray and to block out undercuts on casts.

DENTURE RESINS

A variety of materials have been used over the years to make denture bases. Today, a plastic material is the most universally used. The chemical name is methyl metacrylate. The common name is acrylic resin.

Acrylic resins are supplied as a liquid (monomer) and a powder (polymer). The "cure" (hardening) of the acrylic resin takes place by a reaction between the powder and the liquid known as polymerization. In heat-cured acrylic resins, polymerization is brought about by heat. In autopolymerizing (self-curing) acrylic resins, polymerization is chemically activated at room temperature.

You will use self-curing acrylic resins for denture repairs and to fabricate impression trays. Take care when handling liquid monomer; it is highly flammable and is a skin and eye irritant known to cause allergic reactions.

Acrylic resin is especially susceptible to contamination while it is being mixed and placed. Use clean measuring containers and wear gloves when handling the resin. To ensure a proper cure, shake the liquid before using it. The chemical activators that cause polymerization are lighter than the liquid and tend to rise to the top of the bottle.

SEPARATING MEDIA

Acrylic resins cannot be cured on either dental plaster or stone because they both are quite porous. Consequently, acrylic resin must be separated from the surface of the cast. A separating medium is used for the purpose. It coats the cast, sealing off the pores. This prevents liquid resin from penetrating the cast. (If any resin soaks into the cast, some gypsum will be joined to the surface of the denture base and removal will be difficult.) The separating medium also prevents water in the gypsum from being incorporated into the resin and possibly affecting polymerization.

Tinfoil substitute is a film-forming material commonly used as a separating medium. It is a liquid that is painted on the cast with a soft brush. Because it is affected by moisture, take care not to bring it in contact with water. The film is fragile and easily scuffed. So if part of the film lifts off the cast, remove the entire film and repaint. The film tends to deteriorate, so place the acrylic resin within an hour after you apply the tinfoil substitute.

Care in the use of tinfoil substitute is very important. If gypsum particles get into the bottle of

tinfoil substitute, it cannot be used as a separator. It is best not to work directly from the bulk bottle.

ARTIFICIAL TEETH

Artificial teeth used in dental prosthetic appliances are made of either porcelain or plastic. They replace missing natural teeth for both aesthetics and function. They are furnished in a variety of sizes, shapes, and colors (shades). The manufacturers mount them on cards in anterior and posterior tooth sets. A full complement of denture teeth is only 28 teeth because third molars are not used in dentures.

Artificial teeth are usually identified by mold numbers which indicate their size and shape. The numbers are located on the side of the mounting card and are usually found on the ridgelap (portion that attaches to the denture base) of the artificial teeth. The numbers may also appear as imprints in the base of a completed denture. To help in distinguishing right posterior teeth from left posterior teeth, further identifying marks appear on the mesial portion of the ridgelap. A single raised dot in that area identifies a first bicuspid or a first molar. Two dots identify a second bicuspid or a second molar.

EQUIPMENT

Most prosthodontic operatory equipment is the same as that found in other dental operatories. Equipment unique to a prosthodontic operatory includes such items as an alcohol torch, a Bunsen burner, a vacuum adapter, a bench lathe, and a laboratory handpiece with or without an engine. Although not physically located within the operatory itself, a vibrator, a cast trimmer, and a pneumatic curing unit are also available in another area of the clinic.

VIBRATOR

The vibrator (figure 6-1) is used to get a dental plaster or dental stone mix to move when pouring casts. The vibrator also increases the density of the mix by eliminating air.

To maintain the vibrator, simply clean the pouring platform and body of the unit. As a safety precaution, check the power cord and plug for defects before each use.

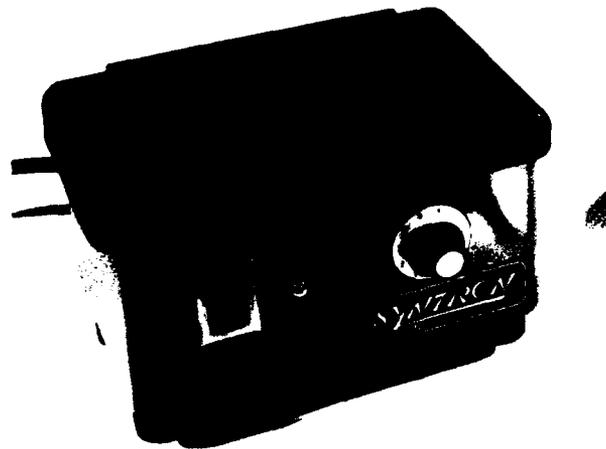


Figure 6-1.—Vibrator.

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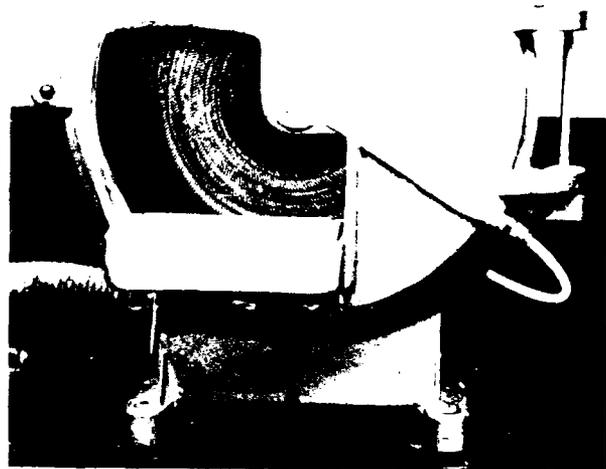


Figure 6-2.—Cast trimmer.

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CAST TRIMMER

The cast trimmer (figure 6-2) is used to trim and contour casts to a workable size. Before using the trimmer, ensure that its water supply is on. The water sprays over the trimming wheel to prevent grindings from spraying the operator. A good practice is to let the water run at least 1

minute after the grinding is complete. This should flush most particles from the trimmer's drain and prevent clogging.

When operating the trimmer, **BE SURE TO KEEP YOUR FINGERS AWAY FROM THE WHEEL. WEAR SAFETY GLASSES OR GOGGLES.** Apply the cast to the trimming wheel, using only light pressure. Ensure that the water spray is sufficient to contain the grindings. Check the unit for water leaks and the power cord for wear or damage. If the unit does not operate smoothly, call a dental equipment repair technician. Consult the manufacturer's instructions for cleaning and user maintenance.

ALCOHOL TORCH

The alcohol torch (figure 6-3) is ideally used to smooth waxed surfaces, setting up teeth, waxing, and for a variety of tasks that demand accurate control of a pointed flame. It draws fuel through a wick from a reservoir near the top of the torch.

Periodically trim all irregular or burned areas of the wick with a small pair of scissors. Check the nozzle tip to ensure that it is free from obstructions. If necessary, draw a thin wire through the nozzle to clean it.

The direction of the flame is controlled by the handoperated trigger or pump, which forces air through the nozzle. When the pump fails to generate sufficient air volume, the seal around the

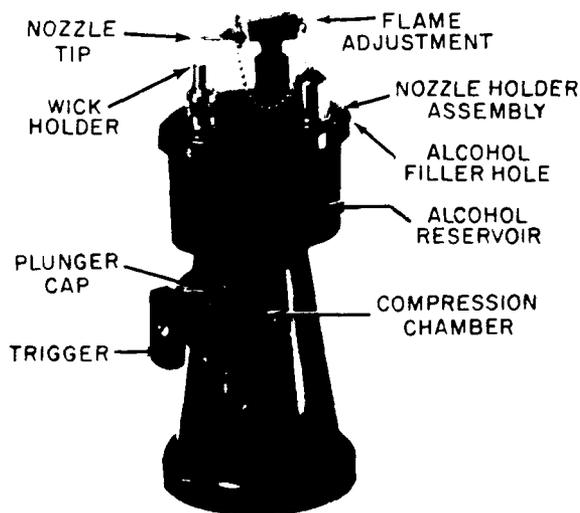


Figure 6-3.—Alcohol torch.

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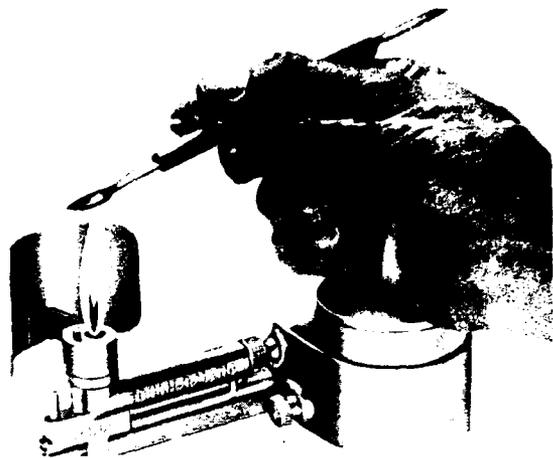


Figure 6-4.—Bunsen burner.

278.180X

plunger cap may need repair. Remove the two screws on the cap and remove the plunger unit. Clean the compression chamber, and apply a thin coat of petrolatum to the plunger rim. Clean the exterior of the pump after each use to prevent accumulation of waxes.

Never over-fill the fuel reservoir. **DO NOT** leave the torch unattended when it is lit. Extinguish the torch when not in use by covering the wick with the attached wick shield.

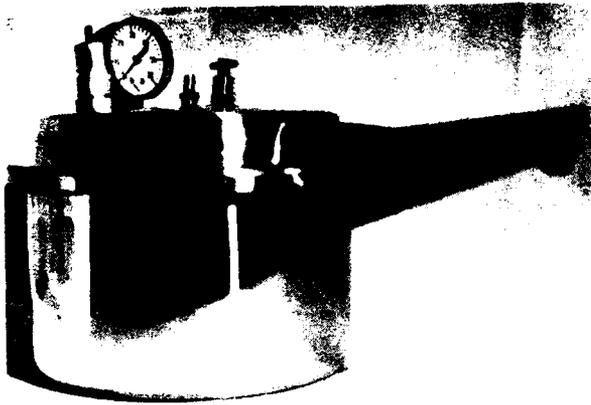
BUNSEN BURNER

The Bunsen burner (figure 6-4) is used to heat wax-carrying instruments. It requires a balanced air/gas mixture to produce a clean blue flame. It is attached to a gas valve with a noncollapsible hose.

User maintenance consists of replacing the hose when worn and removing spilled wax. Remove the burner from the unit and clean it in boiling water to remove the wax. As a safety precaution, inspect the unit and hose for loose connections and defects. Never leave a lighted burner unattended nor reach over the burner. The flame is almost invisible and can cause serious burns.

PNEUMATIC CURING UNIT

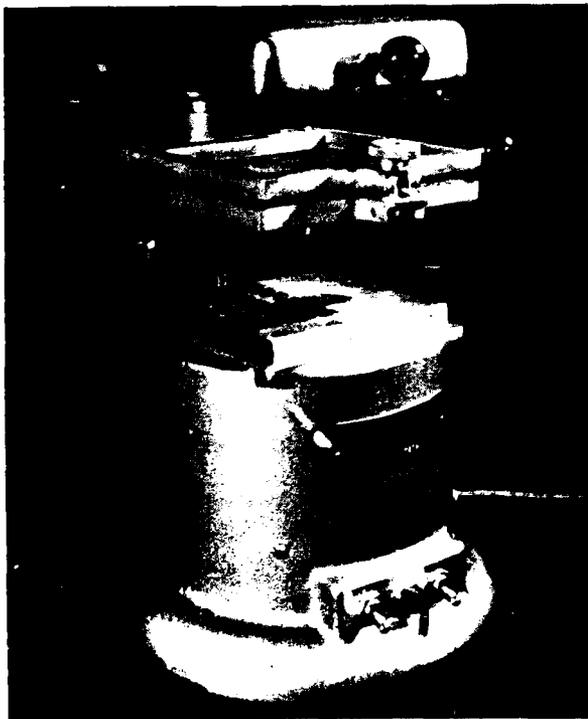
The pneumatic curing unit (figure 6-5), commonly called a pressure pot, assists in the polymerization of self-curing acrylic resins. It is used to cure relines and repairs of complete and removable partial dentures. Curing of the resin



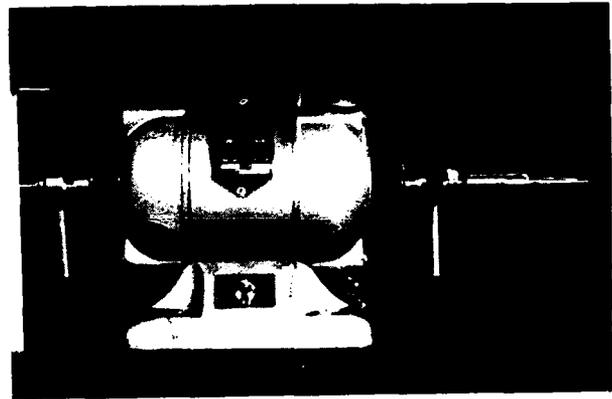
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Figure 6-5.—Pneumatic curing unit.

under pressure significantly reduces the possibility of pores or voids within the resin. Lukewarm water (115 °F) is usually placed in the pot to hasten polymerization.

Periodically check seals and air inlets and outlets for malfunction. Activate the pressure



278.121X
Figure 6-6.—Vacuum adapter.



278.171X
Figure 6-7.—Bench lathe.

relief valve to ensure that it is operational. When necessary, lubricate the large “O” ring inside the lid with petrolatum.

Although the unit has a safety valve, **NEVER** exceed the maximum air pressure indicated in the manufacturer’s instructions. Excessive pressure may cause the pot to explode.

VACUUM ADAPTER

The vacuum adapter (figure 6-6) is used for rapid fabrication of custom impression trays, mouth guards, and bite guards. Also called a vacuum former, the adapter softens a sheet of plastic (or acrylic resin) and draws it onto a cast with suction.

Always use the proper handle to raise and lower the plastic sheet and the heating element. Inspect the vacuum holes in the platform to make sure they are unobstructed. Clean the exterior of the unit and inspect the electrical cord and plug before each use.

BENCH LATHE

The bench lathe (figure 6-7) is used in the grinding, finishing, and polishing phases of prosthesis fabrication. Because the bulk of the lathe is enclosed and sealed, only minor dusting is required on the exterior surfaces.

Wear protective glasses or goggles during all procedures involving the bench lathe. Do not leave a running lathe unattended, and do not attempt to stop the lathe by grasping the attachment with your hands. Ensure that all chucks and attachments are securely mounted before starting the lathe.

The lathe is used with rotary instruments (burs, stones, and ragwheels, etc.). An adapter and/or chuck is required to attach these instruments to the lathe. The lathe shown in figure 6-7 is equipped with an adapter and an arbor band chuck attached to the right spindle (or shaft). Descriptions of adapters and chucks follow.

Adapters

An adapter retains a chuck on the bench lathe. It attaches to the spindle of the lathe and is held in place with three set screws. An adapter is either right-sided or left-sided; i.e., it attaches to either the right or the left side of the lathe. When replacing an adapter, be sure to mount the correct adapter on the correct side of the lathe.

WARNING: *If you use the wrong adapter, it will not retain the chuck when the lathe is in use. This creates a flying object safety hazard.*

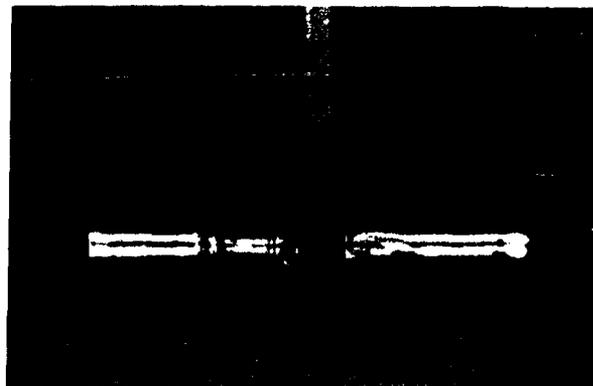
Maintenance of an adapter includes cleaning and, when necessary, spring replacement. The adapter must be disassembled to accomplish the maintenance. Follow these procedures:

1. Loosen the three setscrews on the adapter (figure 6-8) and remove it from the spindle. Use a small screwdriver to remove the retention screw holding the adapter base and cover together.
2. Carefully open the adapter to reveal the opening to the roller bearing chamber



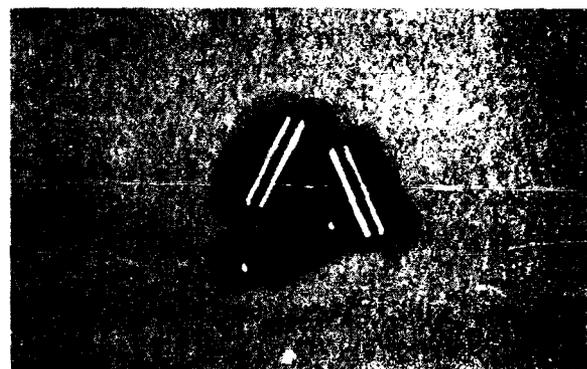
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Figure 6-8.—Loosening setscrew on adapter base.



278.173X

Figure 6-9.—Adapter opened, showing leaf spring and bearing chamber.



278.174X

Figure 6-10.—Adapter roller bearings.

(figure 6-9). Remove the three roller bearings (figure 6-10) from the chamber and put them in a safe place.

3. The leaf spring is to the left of the bearing chamber. If it needs to be replaced, remove the leaf spring and carefully note its position. The replacement spring must be placed in exactly the same position. If it is not, the adapter will not operate properly.
4. After removing the cover, wipe all internal surfaces of the adapter and the bearings with a 2 × 2 inch gauze pad or a cotton-tipped applicator moistened with alcohol.
5. Reposition the roller bearings and put the adapter together. Insert and tighten the retention screw and place the adapter on the spindle. Be sure it is centered on the spindle before tightening the setscrews.

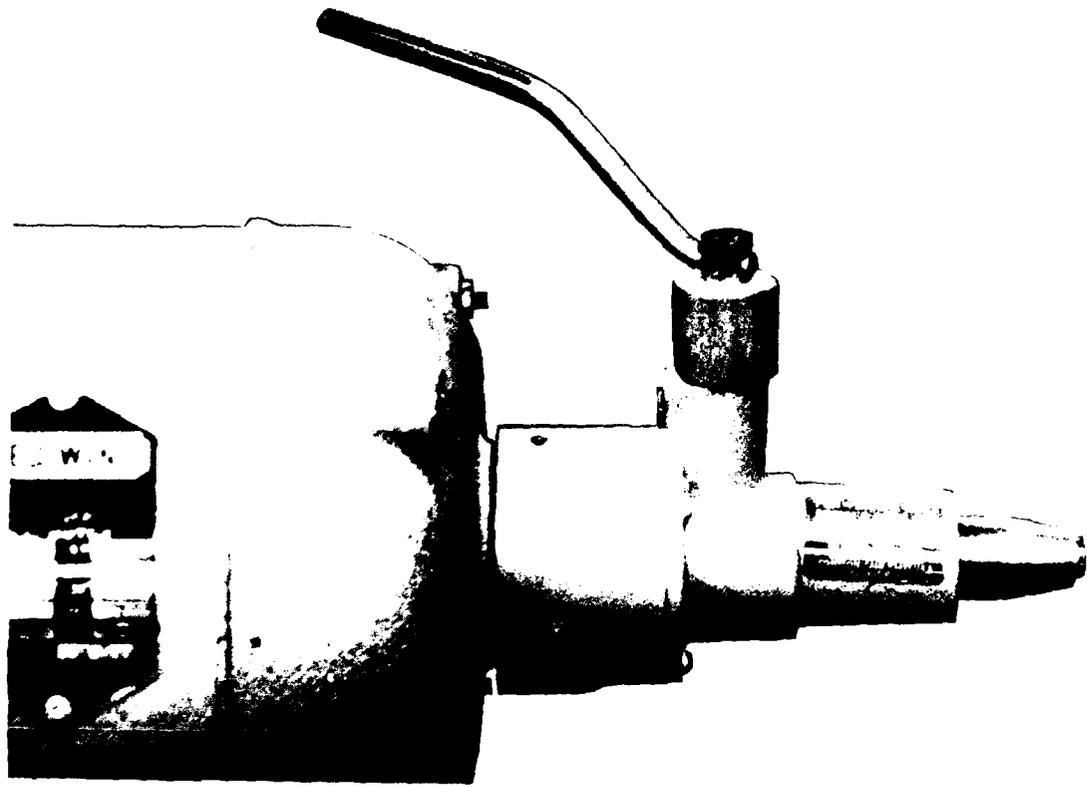


Figure 6-11.—Universal-type adapter for bench lathe.

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Figure 6-12.—Mandrel chuck.

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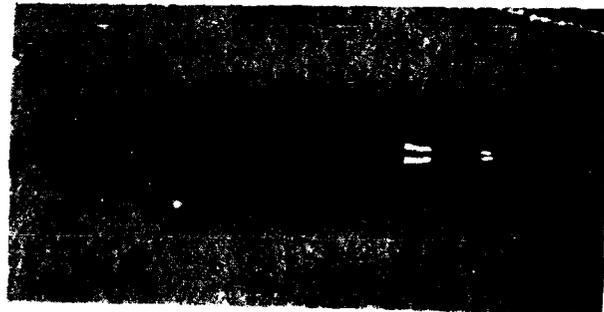


Figure 6-13.—Bur chuck.

278.178

NOTE: The adapter shown in figure 6-11 is quickly becoming the adapter of choice. Unlike the adapter described above, it mounts on the lathe housing (not on the spindles). It accepts most standard chucks and instruments. These items are changed quickly and safely with the simple movement of a lever. Because the bearings are factory sealed, maintenance is limited to cleaning and lubricating the collet (chuck-holding sleeve). Consult the manufacturer's instructions for lubricating procedures.

Chucks

Three chucks commonly used with a bench lathe adapter are the arbor band, the mandrel, and the bur chucks. Each holds a particular type of instrument. The arbor band chuck holds an arbor band (shown in figure 6-7 attached to the lathe); the mandrel chuck (figure 6-12) is commonly used to hold a stone wheel; and the bur chuck (figure 6-13) holds long-shanked handpiece



278.179
Figure 6-14.—Tapered screw chuck.

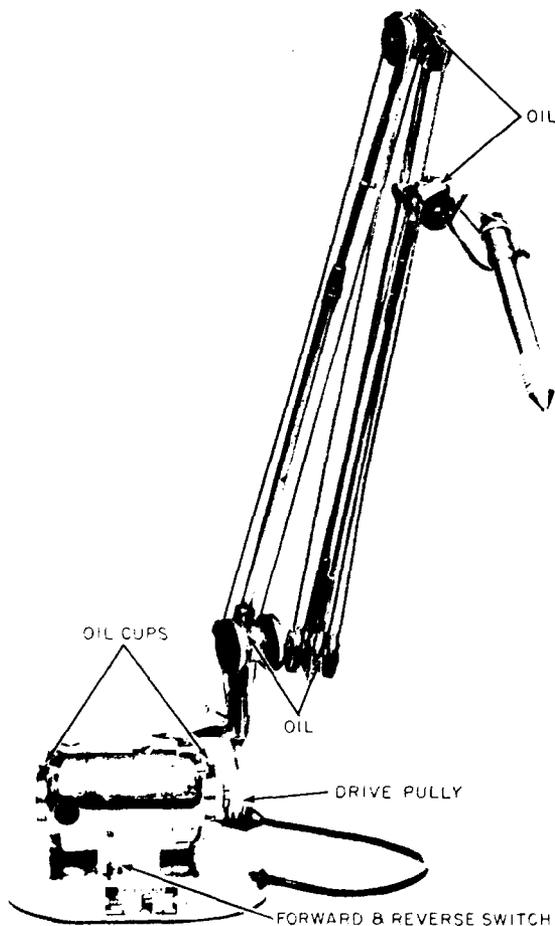
bur or a long-shanked mandrel for a polishing disk or cutting wheel.

Another chuck, the tapered screw chuck (figure 6-14), attaches directly to the bench lathe. It is used to hold a rag wheel, which is secured on the chuck by being twisted onto the threads. The direction of the threads determines whether it is used on the right or left lathe spindle.

LABORATORY HANDPIECE AND ENGINE

The laboratory handpiece, shown in figure 6-15 attached to the bench engine, is used to make adjustments to acrylic resin dentures. It is also used to finish and polish such dentures. The bench engine powers the handpiece and is equipped with a rheostat to vary rotation speed. **NOTE:** Some laboratory handpieces are air driven and are handled and maintained the same as dental handpieces.

Always wear safety goggles when grinding with the handpiece. If the bench engine is used, be sure to keep your hands and fingers away from the drive pulley. Consult the manufacturer's instructions for care and maintenance requirements.



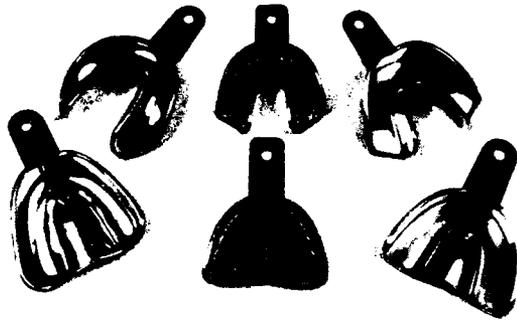
278.183X
Figure 6-15.—Laboratory handpiece and engine.

DIAGNOSTIC IMPRESSION

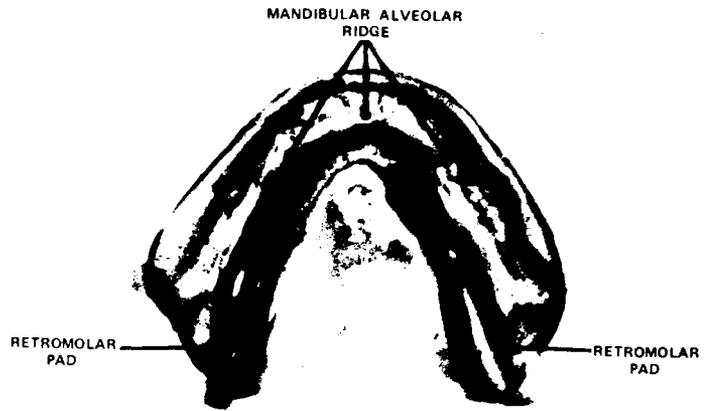
A diagnostic impression, also called a preliminary impression, is the first impression taken of a patient's oral structures. The dental officer may direct you to take the impression of the patient's maxillary or mandibular arch (or both). Alginate impression material and a prefabricated (stock) impression tray are used to take the impression.

Begin by positioning the patient in the dental chair. The patient's head should be against the headrest, with the occlusal plane parallel to the floor. Relax the patient by briefly explaining the steps of the procedure. This should enable the patient to work with you and not against you.

Select the appropriate impression tray. Figure 6-16 shows the commonly used stock trays. These trays are available in sizes ranging from small to



278.152X
 Figure 6-16.—Impression trays: mandibular (top) and maxillary (bottom).



278.154
 Figure 6-18.—Anatomical landmarks of mandibular arch.



278.153
 Figure 6-17.—Anatomical landmarks of maxillary arch.

extra large. Select a tray that is large enough to cover all teeth in the arch. The tray should extend distally beyond the alveolar tubercles of the maxillary arch or the retromolar pads of the mandibular arch. If the patient is edentulous, the tray should cover the entire alveolar ridge and extend just distal to the tubercles or retromolar pads (figures 6-17 and 6-18).

To take the diagnostic impression, follow these steps:

1. Once you have selected the proper tray, apply dental utility wax to its distal end. Applied as shown in figures 6-19 and 6-20, the wax helps keep the impression material in the tray. It also ensures that the impression conforms to the contours of the dental



278.155X
 Figure 6-19.—Utility wax applied to distal end of maxillary impression tray.



278.156X
 Figure 6-20.—Utility wax applied to distal end of mandibular impression tray.



278.157X
 Figure 6-21.—Utility wax applied to distal end and palatal portion of impression tray.

arch. If the patient has a very high palate, you may have to apply utility wax to the palatal portion of the tray (figure 6-21). Doing so ensures that the bulk of the impression material is consistent throughout the palate.

2. Have the patient rinse vigorously with water to remove excess saliva from the mouth. Mix the alginate and load the prepared tray. (You may wish to review these procedures in *Dental Assistant, Basic*.)
3. Place the tray in the patient's mouth. Use your fingers to apply gentle pressure to the trays occlusal surface. Gently seat the tray until the impression material flows out into the facial areas and over the posterior portion of the tray. While seating the tray, ask the patient to relax, take short breaths through the nose, and flex the head forward. Watch for excess alginate that may run down into the patient's throat and incite gagging. If this occurs, quickly draw away the material with a mouth mirror.
4. Hold the tray in place until the impression material has set. The setting time depends on the impression material, i.e., regular or quick-setting alginate. Always follow the manufacturer's instructions in determining the correct setting period.
5. Once the material has set, remove the tray. Remove the maxillary tray by applying pressure to the handle in a straight downward and slightly outward motion. Do not

rock the tray back and forth, because this can distort the impression. Remove a mandibular tray by pulling upward and outward. Briefly rinse the impression with water to remove saliva. Shake the tray to remove excess water. Disinfect the impression by spraying it with a disinfecting solution.

Immediately cover the impression with a damp 4 × 4 inch gauze pad. If the cast is to be poured at the prosthetic laboratory, send it there without delay. If you are to pour the cast, follow the procedures given below.

DIAGNOSTIC CAST

Diagnostic casts are poured from diagnostic impressions. They are used to evaluate the patient's oral structures for denture work and for custom tray construction. They can also be used for making interim (temporary) fixed restorations.

Because impression material is easily distorted, you must handle all impressions carefully. Never touch the impression material with your fingers or with instruments. Carry the tray by its handle. Do not rest the material against the table or bench top. If you are to pour the diagnostic cast, ensure that you have a vibrator, dental stone, a liquid measuring container, a rubber mixing bowl, a 4 × 4 inch plastic slab, and a spatula ready for use. Unwrap the gauze from the diagnostic impression. Wash the impression with a thin plaster-water solution to remove any remaining mucus or saliva (figure 6-22). Remove all excess water,

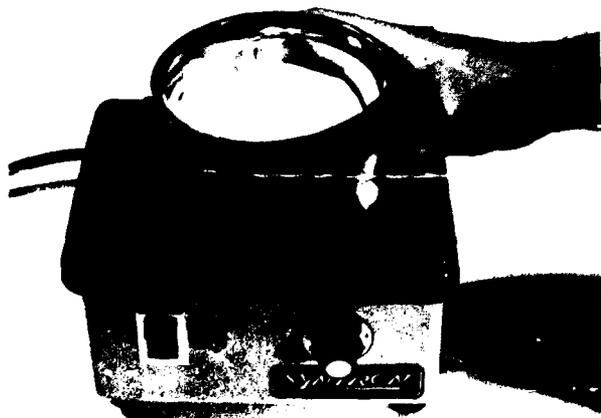


279.35
 Figure 6-22.—Washing impression with plaster water.

but do not allow the impression to become completely dry.

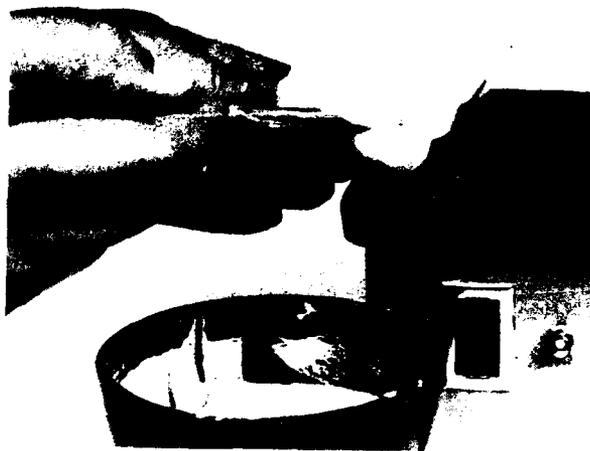
When pouring a cast, you must capture the surface detail of the impression with few or no air bubbles. To do this, closely follow the procedures given below. These procedures are for the two-step method of pouring diagnostic casts. In this method, a cast is developed in two pours. The first fills the anatomical portion of the impression; the second provides the base.

1. Mix the dental stone. Remember the importance of the water-powder ratio of the dental stone. Carefully measure the water and place it in a clean rubber mixing bowl. Next, measure the stone powder. Gradually add the powder to the water, allowing the particles to sink into it. With this method, less air is carried into the mix than if a large quantity of powder is stirred in at one time. Spatulate the mix with a rapid stirring motion for 1/2 to 1 minute. Contact the entire inner surface of the bowl with the spatula so no powder is left unmixed. Do not whip or fold the mix, because this incorporates air into the stone.
2. After spatulation is complete, place the mixing bowl on the vibrator (figure 6-23). Vibrate the mix for 20 to 30 seconds.
3. Rest the impression tray on the vibrator and begin filling the impression with the stone mix (figure 6-24). Add the stone mix at one of the posterior ends of the impression, and allow the mix to flow around to



267.137X

Figure 6-23.—Placing the mixing bowl on the vibrator.



267.138X

Figure 6-24.—Filling the impression tray with stone mix.



267.139X

Figure 6-25.—Covering the borders of the impression with stone mix.

the other end. The vibrator intensity should be enough to make the material move across the surface of the impression. The vibrator is set too high if the impression tray jumps in your hand, if the mix moves so fast that it skips over surface detail, or if vibration wave patterns develop on the stone's surface. Completely fill the impression and cover the borders with additional stone mix (figure 6-25). To aid retention between the two pours, leave nodules and

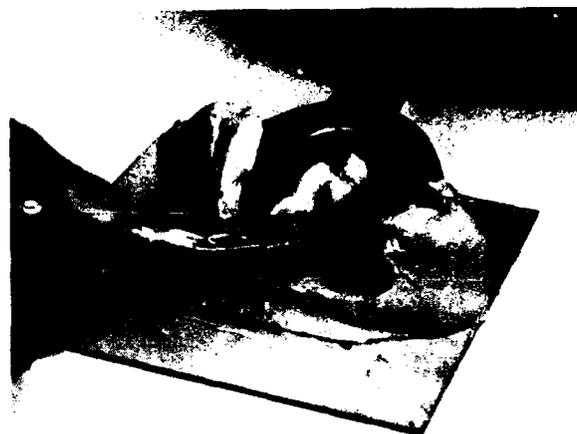
roughened peaks on this first pour. If pouring two casts, repeat the procedures to fill the other impression. Suspend the poured impression by its handle from a tray holder. Do not apply pressure to the filled impression or attempt to smooth the surface of the stone. Either procedure may distort the impression.

4. After the first pour sets, prepare a new mix of dental stone following the procedures described above.
5. Place the mix on a plastic slab and form it into a mound. Smooth the top and sides on the mound until it is the same size and shape as the filled impression tray. Build up a base thickness of about 18 mm (3/4 inch).
6. Invert the filled impression tray onto the mound of stone mix. With a plaster knife or spatula, shape the stone around the impression border (figure 6-26). For a mandibular impression, smooth the mound between the lingual flanges (tongue area) of the tray and trim excess stone (figure 6-27). This prevents the cast from locking onto the impression tray.

After the cast has completely set, check to see if any stone has flowed over the tray edges. If so, carefully remove it with a plaster knife. Remove the diagnostic cast from the impression tray. Be careful not to damage the cast. Remove a



267.140X
Figure 6-26.—Shaping the stone mix around the border of the impression (right); impression with properly shaped border (left).



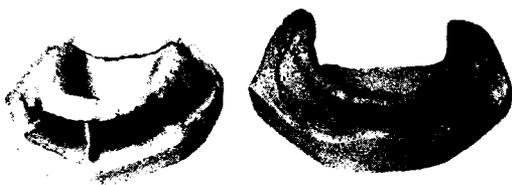
267.141X
Figure 6-27.—Removing excess stone mix from between the lingual flanges of a mandibular impression tray.



267.143
Figure 6-28.—Properly trimmed maxillary (left) and mandibular (right) diagnostic casts.

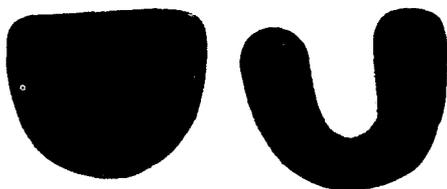
maxillary cast by loosening and lifting the **POSTERIOR** part of the impression tray and withdrawing the tray toward the anterior of the cast. Remove a mandibular cast by loosening and lifting the **ANTERIOR** part of the tray and withdrawing the tray in a vertical direction.

Trim the cast on a cast trimmer. Actuate the trimmer, rest the bottom of the cast on the trimmer's grinding platform, and hold a side of the cast against the grinding wheel. Wear safety goggles while trimming the cast and ensure that water flow to the wheel is sufficient to contain the gypsum particles. Trim until you have a 3 mm margin surrounding the border of the cast. When finished, your cast should resemble one of those shown in figure 6-28.



279.42

Figure 6-29.—Undercuts blocked out on diagnostic casts.



279.43

Figure 6-30.—Acrylic resin shaped for a maxillary tray and a mandibular tray.

Place patient identification data (case number or patient's name) on the bottom surface of the cast. Use an indelible pencil or scribe the data with an instrument. Return the trimmed cast to the dental officer, who will survey it and outline the areas for a custom impression tray.

CUSTOM TRAYS

Prefabricated trays are made to fit everyone moderately well and no one very well. A custom tray, on the other hand, provides the dentist an impression tray more suited to the patient's dental arch. The custom tray, normally used to take a final impression, is made on a diagnostic cast. After surveying, the dental officer draws the design for the custom tray on the cast. At this point, you may be required to fabricate the tray.

The following paragraphs concern the making of a custom tray from autopolymerizing acrylic resin dough. This is the generally preferred method, because it produces a tray that is rigid and dimensionally stable.

1. The first step in custom tray construction is to block out the undercut areas on the cast. This is done so the finished tray can

easily be inserted and removed from the patient's mouth. Use baseplate wax to fill in all undercuts within the tray area outlined on the cast (figure 6-29).

2. Paint the cast with two layers of tinfoil substitute to prevent the acrylic resin from adhering to the cast. Use a soft artist's brush to paint the liquid, and allow the first coat to dry before applying the next. Remember, the film is quite fragile once applied, so handle the cast carefully.
3. Mix the self-curing acrylic resin material in a paper cup. Always follow the manufacturer's monomer-polymer proportioning directions. Don a pair of gloves. When the mix becomes doughy, remove it from the cup and place it in a bowl of cold water for about 5 seconds. This reduces the exothermic heat generated during curing. (Exothermic heat is that which is generated within acrylic resin material due to the chemical combination of polymer and monomer).
4. Apply a light coat of petrolatum to your fingers and knead the acrylic resin for 20 to 30 seconds. The petrolatum will prevent the resin from sticking to your gloved fingers while working with it. For a maxillary tray, roll the resin flat and shape it as shown on the left in figure 6-30. For a mandibular tray, roll the resin flat but form it into a U-shape as shown on the right in figure 6-30.
5. Center the preshaped acrylic resin over the cast and carefully adapt the dough to the surface of the cast (figure 6-31). Be careful



279.44

Figure 6-31.—Adapting preshaped acrylic resin material to a maxillary cast.



279.45
Figure 6-32.—Trimming excess acrylic resin.



279.46
Figure 6-33.—Attaching acrylic resin handle.



279.47
Figure 6-34.—Completed maxillary and mandibular custom trays.

not to create thin spots by pressing too hard. Shape the resin so it extends slightly beyond the line designated by the dental officer. With a sharp knife, cut away any material extending beyond the tissue surface of the cast (figure 6-32).

6. Take a small amount of acrylic resin dough and shape it into a handle. The handle must be strong enough to withstand force, and it must be shaped so as not to interfere with lip movement.
7. Moisten an area in the anterior portion of the tray with monomer and attach the handle to the midline of the tray (figure 6-33).

When the self-curing resin is completely cured, carefully remove the tray from the cast, use the procedures given in the section on "Diagnostic Casts" to remove the tray. It should release from the cast without scraping the stone surface.

If the preceding steps were accomplished carefully, tray finishing will be limited to two procedures. First, trim the tray's peripheral area to the dental officer's border markings. Use an arbor band to remove the bulk. Use acrylic finishing stones and burs for finer details. Be sure that there are no sharp edges on the tray's border and that it is at least 2 mm thick. Next, shape the tray's handle to the dental officer's specifications. Figure 6-34 shows completed maxillary and mandibular custom trays.

CUSTOM TRAY WITH SPACER

The tray just discussed was closely adapted to the diagnostic cast. Some dental officers prefer a tray that provides room for a uniform thickness of impression material. Spacers used to develop tissue stops will serve this purpose.

Block out all undercut areas as previously described. To provide the proper amount of space, adapt a layer of baseplate wax to the tray area outlined on the cast. Cut out three small holes (4 × 4 mm pieces) from the baseplate wax over the crest of the ridge at points indicated by the dental officer (figure 6-35). When the tray is made, these holes will be filled with acrylic resin to provide "stops" for the tray.

Apply tinfoil substitute to the stone surface of the cast that will contact the acrylic resin. Apply a thin layer of petrolatum to the wax surface to make removal of the wax from the cured tray easier. The remaining procedures for constructing and finishing the tray are the same as those already discussed. Be certain to clean away all

traces of petrolatum that might be present on the tray.

TEMPORARY CROWNS

In fixed prosthodontic procedures, impressions are made and the tooth is prepared to receive the prosthesis. The prepared tooth must be protected with a temporary crown until the patient's permanent prosthesis is completed. Although temporary crowns are placed for other reasons, they are usually placed to provide this needed protection.

The dental officer will select the crown and cement, but he may direct you to prepare and place the crown. To perform this task, you will need a mouth mirror, explorer, No. 324 spatula, crown and bridge scissors, contouring pliers, and cotton forceps, rolls, and pellets. Calcium hydroxide and thin zinc oxide-eugenol mixes are commonly used as temporary cements. Be sure to use the one specified by the dental officer.

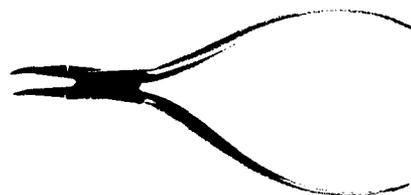
Polycarbonate (tooth-colored plastic) and aluminum shell crowns are the most commonly used temporary crowns. The first are used for anterior teeth and the latter for posterior teeth. They are available in a range of sizes for each tooth, and are almost always too long to use as supplied. Consequently, some trimming and contouring is necessary. If extensive alteration is anticipated, the dental officer may require a temporary crown to be lined before placement. In that case, fill the crown with self-curing acrylic and place it on the prepared tooth. As the acrylic hardens, repeatedly remove and seat the crown. After the acrylic is completely hard, adjust and finish the crown as necessary.

To prepare and cement a temporary crown, follow these steps:

1. Obtain the crown selected by the dental officer. Trim the crown with curved crown and bridge scissors to adapt it to the tooth. To avoid damage to the gingiva, you may have to contour the gingival area of the crown slightly. To contour aluminum shell crowns, use contouring pliers such as the Rocky Mountain No. 114 shown in figure 6-36. **NOTE:** Any cutting on a metal crown results in sharp edges. Before placing the crown, smooth all sharp edges with a flame-shaped greenstone or Barlow wheel.
2. Place the crown over the tooth. Ensure that the crown's margins do not put pressure



279.48
Figure 6-35.—Wax spacer adapted to maxillary and mandibular casts.

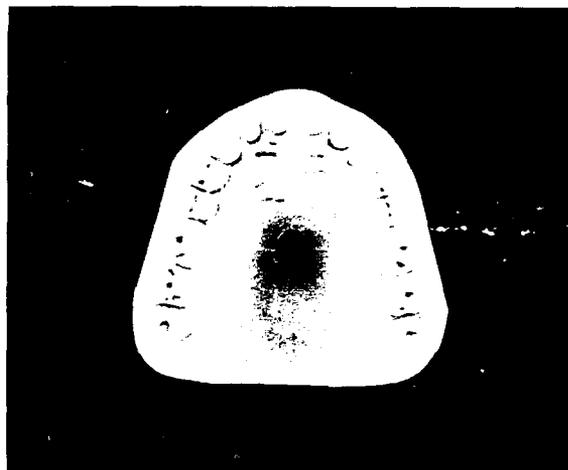


278.106X
Figure 6-36.—Rocky Mountain No. 114 contouring pliers.

on the gingival tissue. If the gingiva turns white when the crown is in place, the crown should be trimmed more. Have the patient gently bite down so you can check for proper occlusion. A crown positioned too high can injure the pulp or gingiva. Remove the crown.

3. To obtain a tight-fitting crown, you may have to punch two or three small holes in its incisal or occlusal surface. Use a sharp explorer for this purpose. The holes will allow excess cement to escape when the crown is firmly seated on the tooth. Most crowns, however, will not require this procedure.
4. Prepare enough of the designated cement to fill the temporary crown. Gather the cement on the blade of the spatula and fill the crown.
5. Dry the tooth by blotting it with cotton pellets or by directing air on it with the air/water syringe.

6. Gently place the crown over the tooth to the gingival margin. Direct the patient to bite down slowly to ensure that the crown is fully seated. Once this is determined, place a cotton roll on the crown's incisal or occlusal surface. Have the patient bite down on the cotton roll for approximately 5 minutes; then remove and discard the cotton roll.
7. Use an explorer to remove all excess cement from the gingival sulcus and interproximal space. Ensure that all debris is removed from the patient's mouth. Gently rinse and evacuate the patient's mouth. Ask the dental officer to inspect your work.



278.122

Figure 6-37.—Cast with hole in center.

BITE GUARD FABRICATION

A bite guard is a U-shaped hard acrylic device that covers the occlusal and incisal tooth surfaces in a dental arch. It protects the teeth and periodontium from trauma due to bruxism or harmful occlusal stresses. Designed to stabilize the teeth, the bite guard provides a flat occlusal surface to minimize tooth attrition.

The bite guard is fabricated for the dental arch with the greater tooth mobility, or the arch with the greater number of remaining teeth. If both arches have the same tooth mobility and number of teeth, the bite guard is made for the maxillary arch.

As an advanced dental assistant, you may be required to assist in making a bite guard. Begin by pouring a plaster cast of the dental arch. Use the diagnostic impression and the same procedures discussed earlier for pouring diagnostic casts. Remember to mix the plaster according to the manufacturer's recommended water-powder ratio. Remove and trim the cast.

To fabricate the bite guard, you will need a sheet of 0.060-inch thick clear acrylic resin material, silicate lubricant, a pencil with an eraser, a vacuum adapter, a self-curing resin kit, and a No. 324 spatula. You will also need a straight handpiece with a silicon carbide disk, a rubber polishing wheel, and a denture-trimming bur.

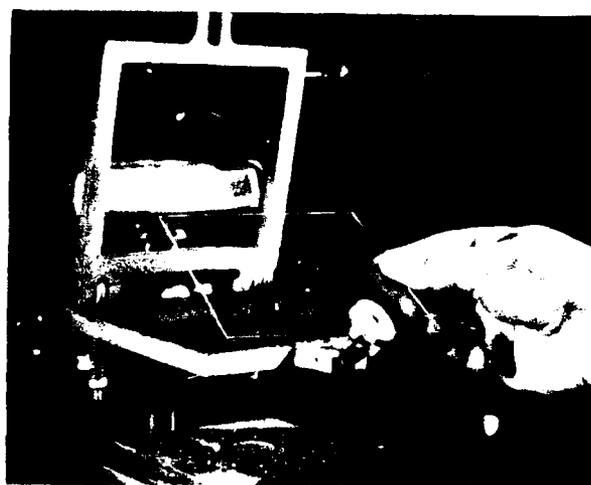
Fabricate the bite guard by following these procedures:

1. Make a hole in the center of the plaster cast with a bur or a sharp knife (figure 6-37).



8.123

Figure 6-38.—Drawing pencil line at height of contour of teeth.



278.124X

Figure 6-39.—Placing sheet of acrylic resin in vacuum adapter.

This ensures that the vacuum adapter will adequately mold the acrylic resin to the cast.

2. With a pencil, draw a line on the cast at the height of contour of the teeth (the largest circumference of the teeth) as shown in figure 6-38. Once this is done, place the cast on the vacuum adapter's perforated plate.
3. Place the acrylic resin sheet in the vacuum adapter (figure 6-39) and secure it with the locking nut. Turn the heating element on and swing it into place over the acrylic sheet. Let the acrylic soften and sag about 1 inch (figure 6-40). Turn the vacuum on and move the frame to the molding position. The vacuum will draw the softened



278.125X

Figure 6-40.—Sag in sheet of heated acrylic resin.

acrylic resin onto the cast (figure 6-41). Once drawn, turn the heating element off.

4. While the acrylic resin is still soft, mold it to the occlusal surfaces and work it into the interproximal areas. Press the softened resin with the lubricated pencil eraser (figure 6-42) or with a lubricated fingertip. Gently work the material into the desired areas. Once the acrylic is adapted, turn the vacuum off and allow the acrylic resin to harden.
5. Remove the case from the vacuum. Use the silicon carbide disk to cut through the acrylic resin and the cast just apical to your pencil line. The part cut free is the bite guard, shown (with plaster intact) in figure 6-43. With a denture-trimming bur, trim the margin of the bite guard to a knifelike edge



278.127

Figure 6-42.—Using lubricated pencil eraser to adapt softened resin to cast.



278.126X

Figure 6-41.—Acrylic resin sheet drawn onto cast by vacuum.



278.128

Figure 6-43.—Bite guard cut from cast.

(figure 6-44). Then smooth and polish the rough edges with a rubber polishing wheel (figure 6-45).

6. Remove the bite guard from the plaster and thoroughly clean it. Give the bite guard to the dental officer, who will place it in the patient's mouth and adjust it as necessary.
7. Prepare the self-curing acrylic resin. Fill a dappen dish one-third full of monomer (liquid), and then add powder. Mixing with a spatula, add powder until a moderately thick paste of acrylic resin forms.
8. Receive the bite guard from the dental officer and moisten its occlusal surface with monomer. Return the guard to the dental officer, who will place a layer of acrylic resin paste on its occlusal surface. This layer (figure 6-46) provides an occlusal table to stabilize the teeth.

The dental officer then inserts the bite guard into the patient's mouth (figure 6-47). After the dental officer guides the patient's mandible into centric relation, the patient is instructed to tap the teeth lightly into the soft acrylic resin. The dental officer then instructs the patient to tap the teeth lightly in their normal occlusal position. Then the dental officer removes the bite guard and immerses it in warm water for 2 minutes. This reduces the setting time for the self-curing resin.

The dental officer removes any excess resin, checks the patient's occlusion, and adjusts the bite guard to ensure maximum contact over the long axis of the teeth. The patient is instructed to glide the mandible in every possible direction until smooth, even passage is achieved. Figure 6-48 shows a properly adjusted bite guard.

After the articulating adjustments have been completed, lightly polish the bite guard with a rubber polishing wheel. Pass the guard back to the dental officer for final fitting. The patient should be recalled in 3 or 4 days, so that the dental officer can check the accuracy of the fit and make any necessary adjustments.

DENTURE REPAIR

Occasionally, you may be required to perform minor repairs on complete and removable partial dentures. Such repairs include putting a fractured denture back together and replacing fractured,



278.129

Figure 6-44.—Trimming margin of bite guard.



278.130

Figure 6-45.—Smoothing and polishing bite guard.



278.131

Figure 6-46.—Layer of acrylic resin on occlusal surface of bite guard.



278.132

Figure 6-47.—Bite guard in patient's mouth, showing untrimmed occlusal table of acrylic resin.



278.134

Figure 6-48.—Properly adjusted bite guard.

missing, or loose denture teeth. Faulty occlusion, poor fit due to mouth changes, or careless handling can cause a denture to break. Identify and correct the cause before you proceed with the repair.

Procedures for denture base and denture tooth repairs are given below. For any repair procedure, you must ensure that the broken or replacement pieces are (1) perfectly clean, (2) assembled with total accuracy, and (3) kept absolutely immobile while the resin is curing.

DENTURE BASE REPAIRS

Figure 6-49 shows a common denture base fracture. Repair procedures for such fractures

consist of aligning the fractured parts, pouring a plaster cast, and applying self-curing acrylic resin. The procedures are as follows:

1. Align the fractured denture parts and apply sticky wax over the fracture line on the external surface of the denture. Because correct alignment is extremely important, it is best to have a helper when joining the pieces. To further stabilize the parts, position used denture burs with sticky wax as shown in figure 6-50. Metal or plastic sticks can also be used for this purpose. Examine the denture to ensure that the parts are properly aligned.



278.158

Figure 6-49.—Fractured denture.



278.159

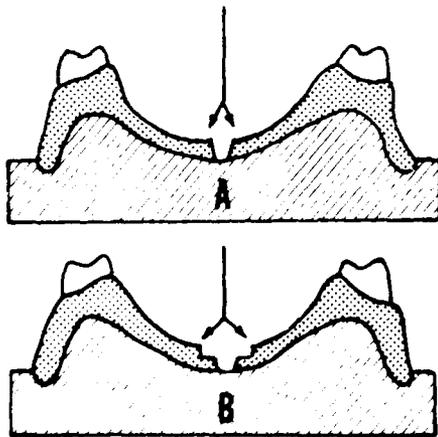
Figure 6-50.—Old denture burs used to stabilize fractured denture parts.

2. Block out all deep undercuts on the denture with wet pumice and prepare a plaster mix. **DO NOT** block out undercuts found along the fracture line.
3. Hold the denture in your hand and gently touch your hand against a vibrator. Slowly pour the plaster into the denture, keeping your hand against the vibrator. Once the denture is filled, place it upright until the plaster sets (figure 6-51).
4. Once the plaster sets, gently remove the denture from the cast. Remove the denture burs and all traces of sticky wax from the denture. Using a new denture bur, widen the fracture lines on the denture as shown in figure 6-52.



278.160

Figure 6-51.—Denture filled with plaster mix.



278.161

Figure 6-52.—Cross section of denture, showing fracture line (A) and widened fracture line (B).

5. Prepare the cast by painting two thin, even coats of tinfoil substitute on it. Be sure the liquid does not form pools on the casts' surface. Excess liquid may cause voids in the repair area.
6. Place the denture parts on the cast in perfect alignment. Tack the parts in position with sticky wax at the posterior edges.
7. Prepare the self-curing acrylic resin by placing equal amounts of monomer and polymer in separate dappen dishes. Use a medium-sized artist's brush to moisten the repair site with monomer. Apply the liquid carefully on raised denture surfaces so it will not flow to lower surfaces.
8. Remoisten the brush with monomer, dip it into the polymer, and apply the powder to the fracture area (figure 6-53). Repeat this procedure until the fracture is covered and slightly overfilled (figure 6-54). The acrylic resin should be uniformly thick throughout the fracture area. Let the denture stand for a few minutes until the sheen disappears from the surface.
9. Place the denture and the cast in a pneumatic curing unit (pressure pot). The occlusal surface should touch the bottom of the pot. Cover the denture with warm water (110 to 125 °F, 43 to 52 °C) and secure the lid. Immersion in warm water speeds up resin polymerization. Attach the rubber tubing to the air valve on the lid and force 25 to 30 psi of air pressure into the pot. The air pressure reduces bubble size, making a denser resin. Keep the denture in the unit for 15 minutes.

NOTE: If a pneumatic curing unit is not available, place the denture in a bowl of warm water for 15 minutes (or until the surface of the resin has hardened). This procedure is **NOT** recommended, but it may be used in an emergency.

10. Gradually turn the petcock on the lid to reduce the inside pressure. Remove the lid only after the pressure gauge indicates zero. Carefully separate the repaired denture from the cast. Using a denture bur, remove any excess acrylic resin from the repaired area (figure 6-55). Polish the repaired surface with pumice and a muslin or brush wheel mounted on a dental lathe. Be sure to wear safety goggles when using the lathe. If a lathe is not available, use a



278.162

Figure 6-53.—Applying polymer to denture fracture line.



278.163

Figure 6-54.—Fracture area covered with acrylic resin.

mandrel-mounted wheel on a straight handpiece. Figure 6-56 shows a completed denture base repair.

Denture Tooth Repair

A complete or removable partial denture may require repair because of loose, fractured, or missing denture teeth. The original tooth can be reattached if it is still intact, but some repairs will require new denture teeth. In either case, the

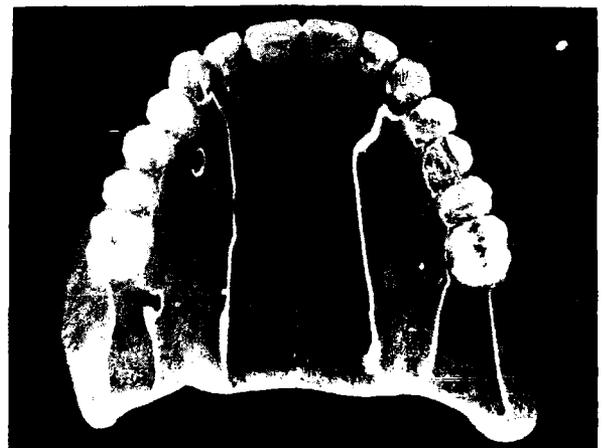
repair is made with self-curing acrylic resin. Following are the procedures for denture tooth repairs.

1. If teeth are loose or broken but still embedded in the denture base, use a denture bur to cut away a portion of the base material from the lingual surface. Do not cut through to the facial surface. Remove only enough denture base material to pop the tooth (or teeth) loose. If the original teeth are being reattached, they should go back to their original position easily and accurately. To ensure retention, trim the lingual portion of the repair area as shown



278.165

Figure 6-55.—Removing excess acrylic resin from repaired area.



278.166

Figure 6-56.—Repaired denture.



278.167

Figure 6-57.—Trimmed lingual portion of denture repair area.



278.168

Figure 6-58.—Two replacement teeth positioned with sticky wax.



278.169

Figure 6-59.—Completed replacement of two denture teeth.

- in figure 6-57. Usually, the facial surface of the denture base need not be disturbed.
2. If new teeth are used, obtain the manufacturer's mold numbers of the original teeth. Select replacement teeth with the same mold numbers. If this information is not available, select the replacement based on the apparent mold of the other denture teeth. The shade is determined from the adjacent teeth with the aid of a shade guide. If an original tooth was altered, the new teeth must be similarly altered. This is done to reestablish the appearance and function of the artificial tooth.
 3. Position the teeth in their seats on the denture base. Ensure that they are properly aligned, and secure them with sticky wax as shown in figure 6-58. Check the denture in occlusion against a cast of the opposing arch.
 4. Apply self-curing acrylic resin to the denture repair areas. Place it in the pressure pot the same as for the denture base repair. When curing is complete, remove excess acrylic resin and polish the repaired area. Figure 6-59 shows a completed denture tooth repair.

SUMMARY

As an advance dental assistant in prosthodontics, you work with many unique dental materials and pieces of equipment. Knowing how to correctly handle, operate, and store these items enables you to properly assist the dental officer and avoid repeating procedures because of error. Take care to follow all safety precautions and perform user-maintenance on equipment as required.

Take a diagnostic impression only when directed by the dental officer. Relax the patient before you begin, and watch for excess alginate that may run down the patient's throat during the procedure. Because the impression material is easily distorted, handle the impression carefully. Pour the diagnostic cast within 10 minutes after taking the impression.

A custom tray provides the dental officer an impression material carrier that is more suited to the patient's dental arch. It is normally used to take a final impression, and it is made on a diagnostic cast. Make a custom tray using autopolymerizing acrylic resin. If the dental officer prefers a tray with a spacer, adapt a layer of baseplate wax to the cast before shaping the acrylic resin on the cast.

Temporary crowns are often placed to protect a prepared tooth until the patient's permanent fixed prosthesis is completed. Polycarbonate and aluminum shell crowns are the most commonly used temporary crowns. Prepare and place the crown, and ensure that the gingival tissue is not traumatized. Be sure to check for proper occlusion and have the dental officer inspect and approve your work.

A bite guard is a device that protects the teeth and periodontium from trauma due to bruxism or harmful occlusal stresses. Fabricate the bite guard by using a vacuum adapter and a sheet of 0.060-inch thick clear acrylic resin. Be sure to polish and smooth the rough edges of the guard

before passing it to the dental officer for adjustment.

Occasionally, you may be required to perform minor repairs on complete and removable partial dentures. You must ensure that the broken or replacement denture pieces are perfectly clean, assembled with total accuracy, and kept absolutely immobile while the acrylic resin is curing. Failure to do so could result in an ill fitting denture and possible trauma to the patient.

REFERENCE LIST

Air Force Manual - AFM-162-6, *Dental Laboratory Technology*, November 1982

CHAPTER 7

EXTRAORAL RADIOGRAPHY

Learning Objectives

Upon completion of this chapter you will be able to:

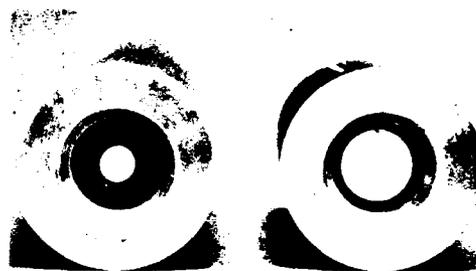
1. Identify extraoral film equipment, its purpose, and its handling requirements.
2. Identify extraoral views commonly exposed in dentistry and recognize their exposure requirements and uses.
3. Identify extraoral film processing requirements and procedures.

In addition to correctly exposing and processing intraoral radiographs, you are required to know how to expose and process certain extraoral radiographs. As their name suggests, extraoral views are taken with the film outside the oral cavity. They are important diagnostic aids when examining the mandible, maxillae, and other bones of the head and neck for disease, injury, or skeletal growth. They can be used in addition to intraoral radiographs, or at times they may be the only radiographic survey possible, for example when the patient cannot open his mouth.

This chapter covers the extraoral views commonly exposed in dentistry. It identifies the equipment needed to expose such views, film handling and processing considerations, and exposure techniques.

EXTRAORAL FILM EQUIPMENT

The same dental x-ray unit used to expose intraoral views is used to expose the extraoral views discussed in this chapter. However, the unit is equipped with a short tubehead cylinder. Because the aperture in the diaphragm of the short cylinder is larger (figure 7-1), it provides a wider radiation



278.33
Figure 7-1.—Comparison of aperture size of the diaphragm of a long cylinder (left) and a short cylinder (right).

beam. A wider beam is necessary to expose the larger area of an extraoral view.

Some of the extraoral views covered in this chapter are skull projections; i.e., they are designed to radiograph and examine the entire skull rather than specific parts of it. They can be exposed using a conventional dental x-ray unit, but some equipment variations do exist.

A cephalometric unit is used to produce skull projections for the orthodontist and the oral surgeon. Referred to as cephalometric radiographs, these views are used to measure head and facial structures for orthodontic and surgical

treatment. Because panoramic and cephalometric radiographs are commonly used together, many manufacturers produce a combined panoramic and cephalometric unit. An example is shown in figure 7-2.

Skull projections require patience, attention to detail, and practice to produce satisfactory results. An important feature of the cephalometric unit is that it enables you to fix the tubehead in a standardized position. A cephalostat, or head positioner (figure 7-3), allows you to position the patient's head in relation to the fixed position of the tubehead. Ear rods and the nose support keep the patient's head motionless during exposure. By these means, you can achieve consistent and accurate results.

EXTRAORAL FILM

Two types of film, screen and nonscreen, are used in exposing extraoral views. They are also used to expose most medical radiographs. Since

the usual method of exposing extraoral views in dentistry employs screen film, our discussion is limited to this type of film. Screen film is always used with film cassettes equipped with intensifying screens. They require less x-ray exposure to produce the desired film density for viewing.

Extraoral screen film is available in several sizes. Most commonly used are 5×7 inch and 8×10 inch film. The size used is dictated by the size of the film cassette available and the area to be radiographed.

Intraoral film is available in individual waterproof and lightproof packages. Extraoral screen film, on the other hand, is supplied in sheets in packages of various quantities. The packages are designed to protect the film from light, and to provide for easy removal of an individual sheet. Some manufacturers use a wrapper or interleaving (slip-sheet) paper with sheet film, to reduce damage due to pressure and resulting static electricity.

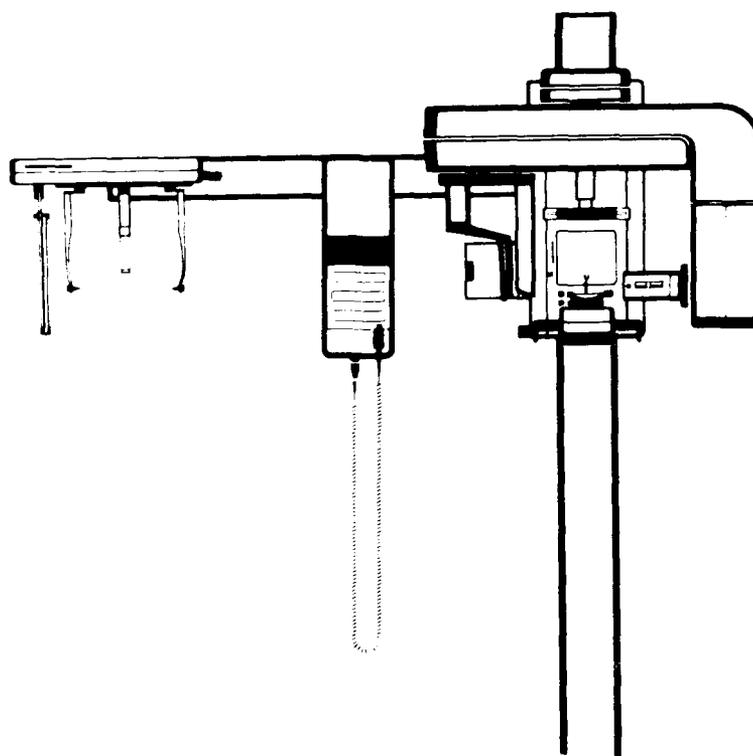
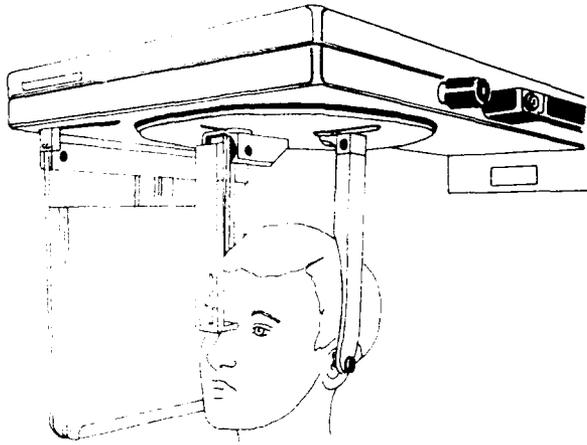
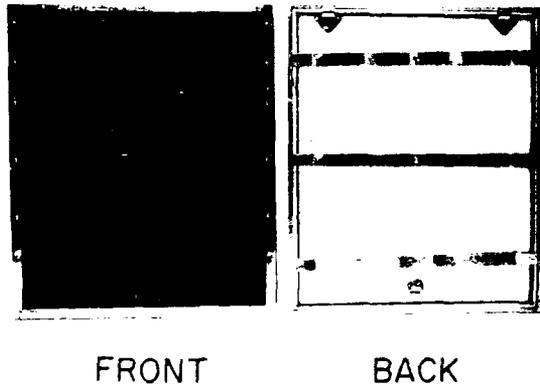


Figure 7-2.—X-ray unit used for Cephalometric Radiography.

278.33.1X



278.33.2X
Figure 7-3.—Cephalostat (head positioner).



278.35
Figure 7-4.—A cassette.

Film Storage

Radiographic film is sensitive to light, heat, moisture, pressure, age, fumes, and chemicals. Storage of sheet film, therefore, deserves special consideration. Sealed packages of sheet film are affected by heat; opened packages are also damaged by humidity. Consequently, film should be stored in a cool room with a temperature of 50 to 70°F (10 to 21.1°C) and a relative humidity of 40 to 60 percent. It should never be left near heat sources such as radiators, steam pipes, or where gases of any kind may leak into the air.

To further protect the film, store all packages on end. This reduces the possibility of pressure marks caused by the combined weight of several packages. Store enough film to provide for a

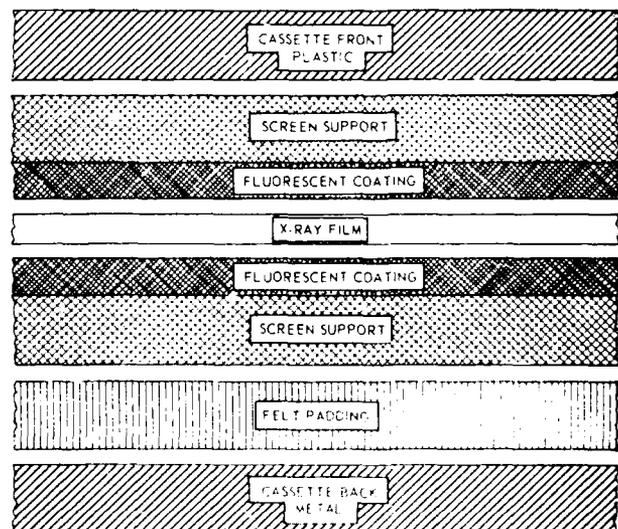
reasonably rapid turnover. Always use the oldest screen film first. Packages are dated, so it is easy for you to tell which film is the oldest.

Film Cassettes

A film cassette (figure 7-4) is a framed, rigid holder used to retain a sheet of film during exposure to x-rays. The cassette contains a pair of intensifying screens between which a sheet of film is placed preceding the exposure.

Intensifying screens intensify the exposure image and, consequently, reduce the amount of radiation needed to expose the image. When screen film is used, the x-ray image is formed by the combined effects of the film emulsion and the intensifying screens being struck by x-rays. Intensifying screens come in various speeds. High image intensity is achieved by using fast speed screens; high image clarity is obtained with slow speed screens, and balance between intensity and clarity is obtained with average speed screens.

Several components make up a film cassette. Figure 7-5 shows a diagrammatic cross section of a loaded cassette. The front of the cassette is made of plastic or Bakelite. It should always face the x-ray tubehead during exposure. The next layer of the cassette is the first intensifying screen, which consists of a screen support and a fluorescent coating. It lies flat against one side of the film sheet. A second intensifying screen lies flat against the other side of the film. It, too, consists of a fluorescent coating and a screen support. Felt



278.36
Figure 7-5.—Diagrammatic cross section of a loaded cassette.

padding follows the second intensifying screen and then the back of the cassette.

The back of the cassette is made of metal and is hinged to permit loading and unloading of screen film. Locking bars secure the cassette and ensure that it is lightproof. By doing so, the cassette protects the film from visible light before, during, and after x-ray exposure.

You must be extremely careful when handling film cassettes. Dust, dirt, chemical stains, or scratches on the intensifying screens may cause white radiopaque areas on the processed radiograph. To reduce the possibility of getting foreign materials on the screens, open the cassette only when loading or unloading screen film. Ensure that your hands are dry and free from processing chemicals. Do not place the film cassette on benches or working surfaces where such chemicals are mixed or stored. Use a clean, damp cloth and a mild soap solution to remove foreign materials from the surfaces of the intensifying screens. Do not use your fingernails or any instruments to remove these materials; doing so may scratch the surface of the screens.

Careless handling of film cassettes can change the alignment of the intensifying screens. Improper contact between the sheet of film and the intensifying screens may result in an unclear image on the processed radiograph. If a cassette is dropped, check the intensifying screens to ensure proper alignment. Improperly aligned, scratched, or damaged intensifying screens should be repaired or replaced.

Labeling the Film Cassette

Both sides of a sheet of extraoral screen film have a light-sensitive emulsion, causing them to appear dull in reflected light. Consequently, screen film must be labeled to indicate the correct viewing position of the processed radiograph. Radiopaque letters are often attached to the film cassette for this purpose.

The letters "R" and "L" are used to distinguish the right side of the patient's dentition from the left on processed radiographs. They must be made of a radiopaque material (usually lead) and taped to the film cassette before you expose the view. Place the letters on the front

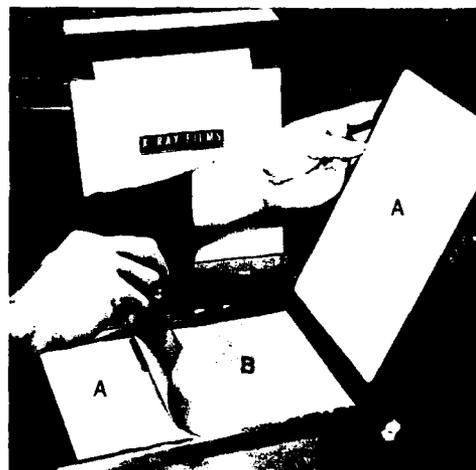
(plastic) surface of the cassette. Attach the letter "R" when you expose an extraoral view of the right side of the patient's dentition. When exposing a view of the left side of the patient's dentition, attach the letter "L" to the cassette. Labeling is extremely helpful for posteroanterior (PA) views and is also recommended for lateral views.

Radiopaque letters and numerals can also be attached to the cassette's front surface for the purpose of patient identification. Correct identification includes the patient's name and social security number and the date of exposure.

Loading and Unloading the Film Cassette

Because of the sensitivity of screen film, you must observe certain precautions when loading and unloading the film cassette. Both procedures must be accomplished only in the darkroom under safelight conditions. If the film is packaged with paper, be sure to remove the paper during the loading procedure. If you don't, the paper will reduce the effects of the intensifying screens and result in an underexposed image.

You must handle screen film carefully to avoid damage due to pressure, contamination, and friction. Handle the sheet of film with your thumb and forefinger, and grasp only the extreme edges.



A. Intensifying screen.
B. Extra-oral film.

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Figure 7-6.—Loading a cassette in the darkroom.

Figure 7-6 shows the correct manner of holding the film when loading a cassette.

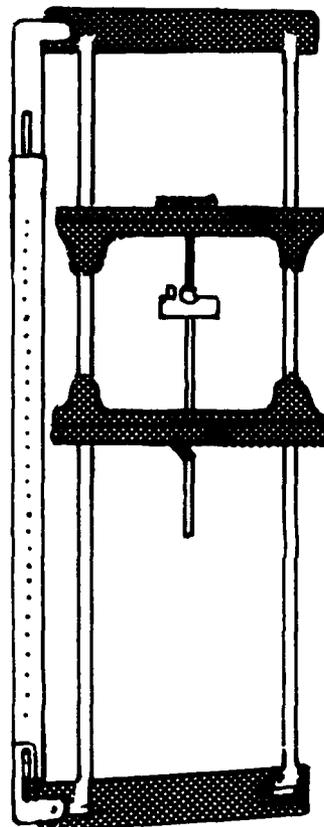
To load a cassette, follow these procedures:

1. Place the cassette on a clean, dry working surface in the darkroom. The cassette's back surface (metal surface) should face upward. Turn the safelight on, and the white light off.
2. Open the film cassette. Loosen the locking bars on the back of the cassette. Depress the bars, turn them counter-clockwise, and lift the back open.
3. Open the film package and remove a sheet of screen film. Be sure to grasp the film only on the extreme outer edge. Use your thumb and forefinger to draw the film slowly from the package.
4. Place the film in the cassette without the paper. The sheet of film should lie flat upon the first intensifying screen, as shown in figure 7-6. Do not kink the film or allow it to rub over the surface of the screen.
5. Gently close and lock the cassette. Depress the locking bars and turn them clockwise.

After the extraoral view has been exposed, return the film cassette to the darkroom. Unload the screen film by following the same procedures used to load the cassette. Remember, load and unload the cassette only in the darkroom under safelight conditions.

EXTRAORAL FILM EXPOSURE

When exposing extraoral views, ensure that the patient, the film cassette, and the x-ray tubehead are properly positioned. This ensures that the processed radiograph shows all the anatomical areas requested by the dental officer. It also avoids repeating the procedure and exposing the patient to additional radiation. When using a conventional dental x-ray unit, you can make positioning easier by using a wall-mounted



278.38

Figure 7-7.—The wall-mounted cassette holder.

cassette holder (figure 7-7), together with an adjustable stool. An adjustable stool may also be used with the cephalometric unit, but the patient normally stands during the exposure. The cephalostat and fixed position of the tubehead ensure proper positioning for a cephalometric radiograph.

The following paragraphs cover the extraoral views commonly requested in dentistry. Because few dental facilities have a cephalometric unit, the procedures and requirements outlined are for exposure with a conventional x-ray machine. The use of the wall-mounted holder and adjustable stool is discussed. If a wall-mounted holder is not available at your facility, the headrest and the back of the dental chair can be used to position the patient and the film cassette. The kilovoltage, milliamperage, and exposure settings recommended may not apply at all dental facilities. Variations may be necessary because of film, intensifying screens, dental x-ray units, and patient size.

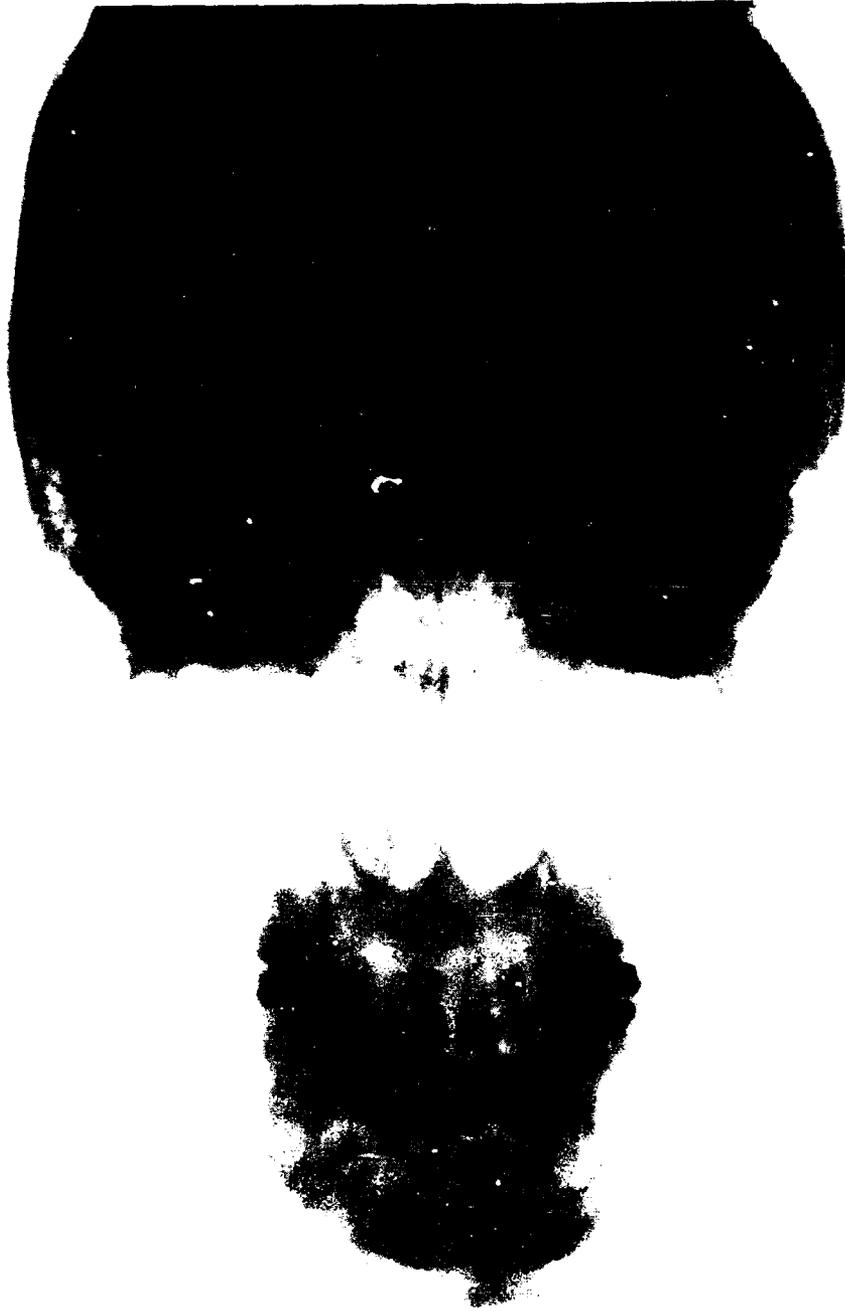


Figure 7-8. --Posteroanterior view.

278.42

POSTEROANTERIOR VIEW

The dental officer will request a postero-anterior (PA) view (figure 7-8) when looking for a displacement or fracture of the condyloid

process, coronoid process, or ramus and angle of the mandibular arch. The PA view is a skull projection and can be used to examine the skull for the presence of disease, trauma, or developmental abnormalities. It is so named because the x-ray

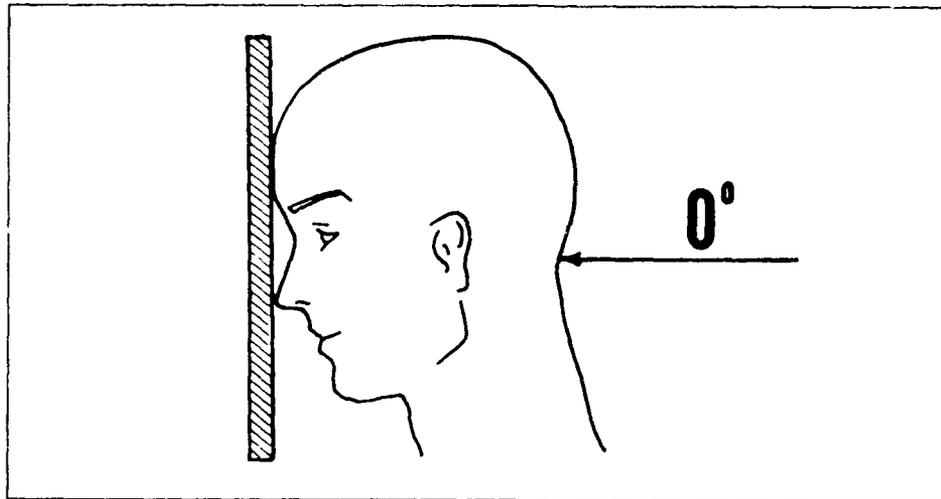


Figure 7-9.—Positions of patient, film, and central beam for a posteroanterior view.

278.39

beam travels from the posterior to the anterior of the patient.

To expose the PA view, perform the following procedures:

1. Set a 8×10 inch cassette upright in the wall-mounted cassette holder.
2. Adjust the stool. When the patient is seated, the patient's head must be centered directly in front of the film cassette.
3. Position the patient as shown in figure 7-9. Touch the patient's forehead and nose against the cassette. Ensure that 1 inch of the cassette extends below the chin. The patient's back must be straight. Instruct the patient to keep his back straight throughout the exposure.
4. Position the tubehead. Set the vertical angulation of the tubehead at 0°. Position the tubehead so that the central x-ray beam is directly midway between the patient's ears, and the target-film distance (TFD) is 36 inches. (The TFD is the distance from the film cassette to the focal spot on the tungsten target inside the tubehead.)
5. Set the kilovoltage switch to 65 kVp.
6. Set the milliamperage switch to 10 mA.

7. Set the exposure timer to 4/5 second (48 impulses).

8. Expose the view.

The PA view is commonly exposed with a cephalometric unit. Patient and cassette positioning are quite similar, but TFD, kVp, mA, and exposure time can vary considerably. The tubehead on most cephalometric units is mechanically fixed for a TFD of 60 inches. The larger TFD increases the definition of the radiograph, decreases magnification of skull structures, and requires an increase in exposure time. Therefore, the cephalometric PA projection is of considerable value to the orthodontist and oral surgeon when measuring skull and facial structures.

TOWNES VIEW (ANTEROPOSTERIOR)

The dental officer will request a Townes view (figure 7-10) when looking for a possible fracture of the condyloid process and the head of the condyle. The Townes view is a skull projection and has the same additional applications as the PA view. It is also referred to as the anteroposterior (AP) view because the x-ray beam travels from the anterior to the posterior of the patient.

To expose the Townes view, perform the following procedures:

1. Seat the patient in the dental chair and lower the backrest a few inches.

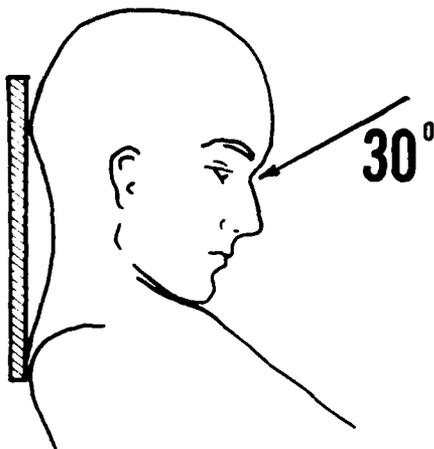


Figure 7-10.—Townes view (anteroposterior).

278.42.1

2. Position the film cassette. Set an 8 × 10 inch cassette upright on the edge of the backrest. The bottom of the cassette should be just below the patient's shoulders. Adjust the headrest so that it supports the cassette in a vertical position.
3. Position the patient as shown in figure 7-11. Set the patient's shoulders back so that they touch the bottom of the cassette. Bring the patient's chin down onto the chest, allowing the occipital bone to touch the top of the cassette.
4. Position the tubehead. Set the vertical angulation of the tubehead at 30°. Position the tubehead so that the central x-ray beam is directed at the bridge of the patient's nose and the TFD is 24 inches.
5. Set the kilovoltage switch to 65 kVp.
6. Set the milliamperage switch to 10 mA.
7. Set the exposure timer to 3/4 second (45 impulses).
8. Expose the view.

The AP view is also a commonly exposed cephalometric view. The resultant radiograph is quite similar to that produced on the conventional dental x-ray unit. The exposure variations



278.40
Figure 7-11.—Positions of patient, film, and central beam for a Townes view (anteroposterior).

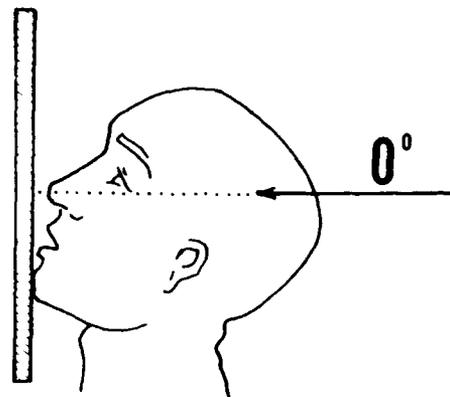
previously described for the cephalometric PA view also apply to the cephalometric AP view.

WATERS VIEW (OCCIPITOMENTAL)

The waters view, also called the occipitomen- tal view, is a variation of the PA view. The dental officer will request this view when looking for a fracture of the zygomatic complex, a "blow-out fracture" of the orbit, or fluid, blood, and soft tissue in the sinuses. It is a skull projection, not normally exposed on a cephalometric unit.

To expose the Waters view, perform the following procedures:

1. Set an 8 × 10 inch cassette upright in the wall-mounted cassette holder.
2. Adjust the stool. When the patient is seated, the patient's head must be directly in front of the cassette.
3. Position the patient as shown in figure 7-12. Touch the patient's chin, with the mouth open, against the cassette. Keep the patient's nose 1/2 inch away from the cassette.
4. Position the tubehead. Set the vertical angulation of the tubehead at 0°. Position the tubehead so that the central x-ray beam is directed at the middle of the head on an imaginary line between the eyes and the nose. The TFD must be 36 inches.
5. Set the kilovoltage switch to 65 kVp.
6. Set the milliamperage switch to 10 mA.



278.41
Figure 7-12.—Position of patient, film, and central beam for a Waters view.

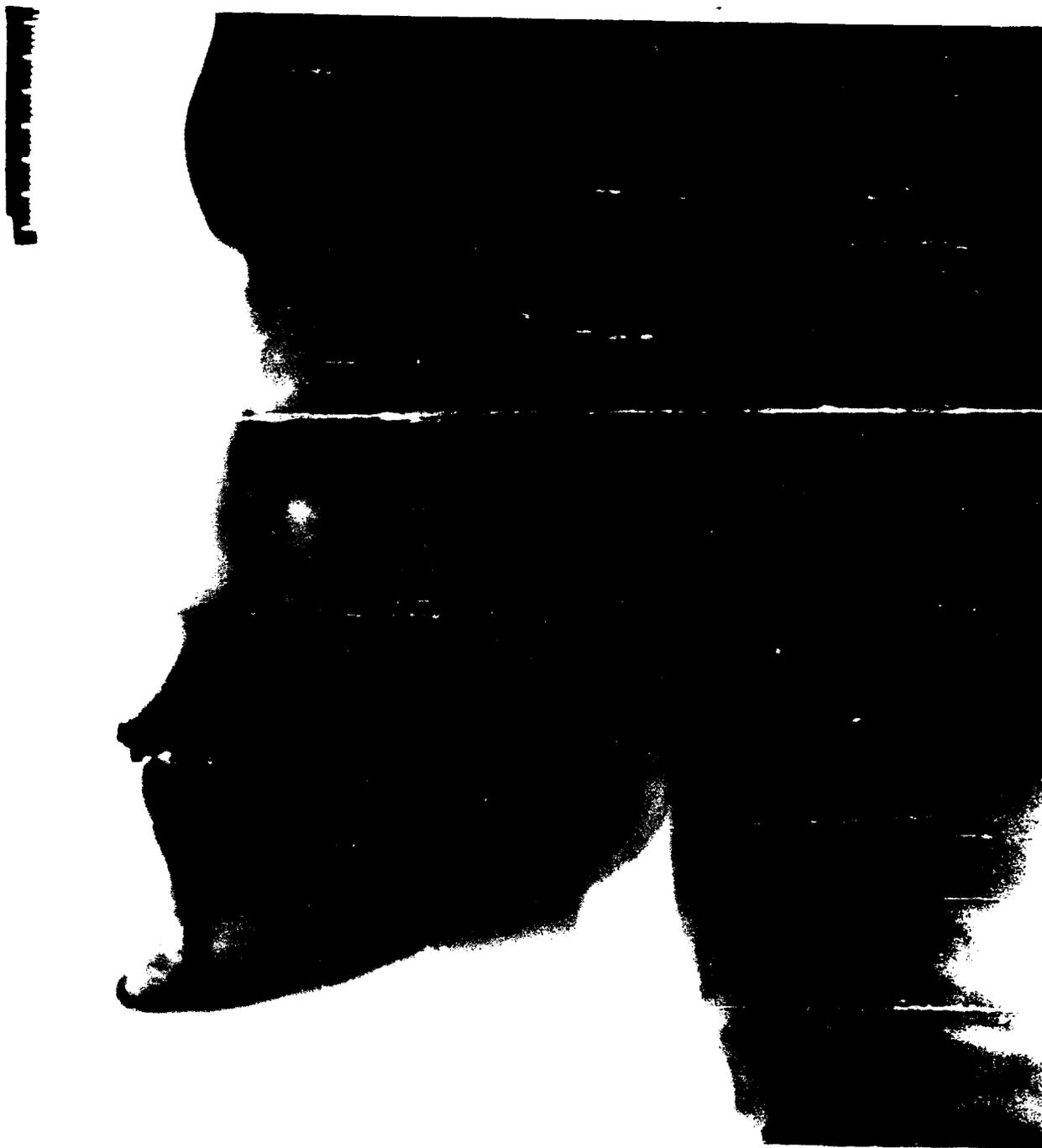


Figure 7-13.—Lateral cephalometric view.

278.42.2

7. Set the exposure timer to 1 1/4 seconds (75 impulses) for male patients, or 3/4 to 1 second (45 to 60 impulses) for female patients.
8. Expose the view.

LATERAL SKULL VIEW

The dental officer will request a lateral skull view when looking for any type of skull fracture, including fractures of the nasal bones or the base of the skull. The dental officer will request a right

or left lateral skull view, depending on the side to be surveyed.

The lateral skull view is the most commonly exposed cephalometric radiograph. The orthodontist uses it to assess facial growth and the oral surgeon often uses it to establish pretreatment records. The lateral cephalometric view (figure 7-13) reveals the facial soft tissue profile, but otherwise it is identical to the lateral skull view.

To expose the lateral skull view, perform the following procedures:

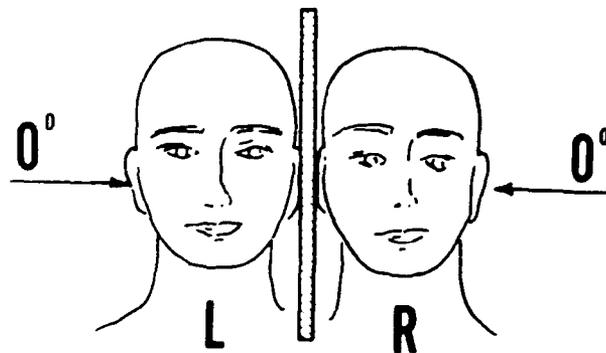
1. Set an 8 × 10 inch cassette sideways in the wall-mounted cassette holder.
2. Adjust the stool. When the patient is seated, the desired side of the patient's head must be directly in front of the cassette. Both the right and left sides of the patient's skull are superimposed upon each other on the resultant radiograph. The side nearer the tubehead is magnified slightly more than the side nearer the film.
3. Position the patient as shown in figure 7-14. Touch the patient's ear against the cassette, keeping the head parallel to the cassette. The patient's chin should be parallel to the floor.
4. Position the tubehead. Set the vertical angulation at 0°. Position the tubehead so that the central x-ray beam is directed at the middle of the ear and the TFD is 36 inches.
5. Set the kilovoltage switch to 65 kVp.
6. Set the milliamperage switch to 10 mA.
7. Set the exposure timer to 1/2 second (30 impulses).
8. Expose the view.

SUBMENTOVERTEX VIEW

The dental officer will request a submentovertex view when looking for a possible fracture of the zygomatic arch. The submentovertex view is a skull projection that also reveals the position and orientation of the condyles and the curvature of the mandible.

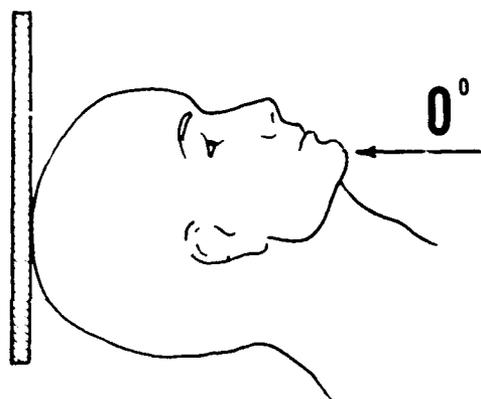
To expose the submentovertex view, perform the following:

1. Seat the patient in the dental chair and lower the backrest until it is almost parallel with the floor.
2. Set an 8 × 10 inch cassette upright in the wall-mounted cassette holder.



278.44

Figure 7-14.—Positions of patient, film, and central beam for Lateral skull views.



278.45

Figure 7-15.—Position of patient, film, and central beam for a Submentovertex view.

3. Position the patient as shown in figure 7-15. Raise the dental chair until the top of the patient's head is directly in front of the cassette. Support the patient's head with the headrest and tilt it back so that the chin protrudes upward in an exaggerated position.
4. Position the tubehead. Set the vertical angulation of the tubehead to 0°. Position the tubehead so that the central x-ray beam is directed below the point of the chin and the TFD is 24 inches.
5. Set the kilovoltage switch to 65 kVp.
6. Set the milliamperage switch to 10 mA.
7. Set the exposure timer to 1 1/4 second (75 impulses).
8. Expose the view.

ZYGOMATIC VIEW

In the zygomatic view, the dental officer will again be looking for a possible fracture of the zygomatic arch. Usually, the dental officer will request both, the zygomatic and the submentovertex view for a more complete radiographic survey.

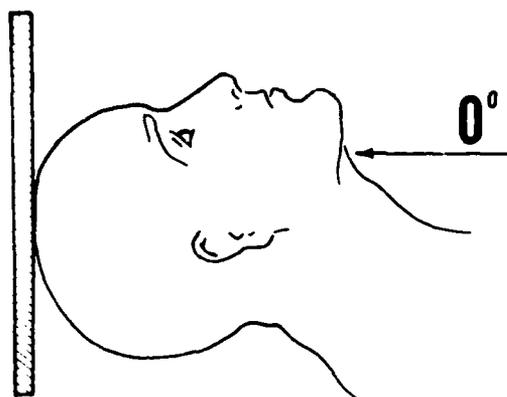
The zygomatic view is exposed like the submentovertex view, except that the patient's head is tilted back even farther (figure 7-16). With the head positioned as such, the zygomatic bone is higher than the forehead. The exposure parameters are the same, except that the central x-ray beam is directed at the midline of the mandible.

LATERAL OBLIQUE VIEW

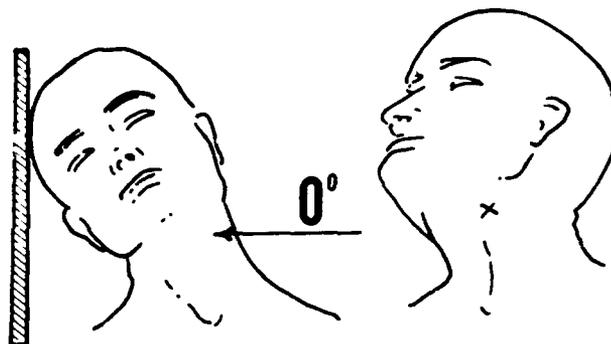
The dental officer will request a lateral oblique (also called lateral jaw) view when looking for a fracture of the ramus (right or left side) near the angle of the mandible. It is also useful in determining the presence of, and examining unerupted and impacted teeth. The area to be radiographed is indicated by the dental officer's request for either a "right lateral oblique" or a "left lateral oblique" view. Remember, the image of the ramus that appears on the processed radiograph will show the ramus positioned closest to the film cassette. Therefore, the right side of the patient's mandible is positioned next to the film cassette when a right lateral oblique view is desired, and vice-versa for a left lateral oblique.

To expose the right lateral oblique view perform the following procedures:

1. Set an 8 × 10 inch cassette sideways in the wall-mounted cassette holder.
2. Adjust the stool. When the patient is seated, the right side of the patient's head must be directly in front of the cassette.
3. Position the patient as shown in figure 7-17. Touch the right upper edge of the patient's forehead to the cassette so that the head tilts 45° to the right. Bring the patient's chin forward in an exaggerated position.
4. Position the tubehead. Set the vertical angulation of the tubehead at 0°. Position the tubehead so that the central x-ray beam is directed under the left side of the mandible and at the middle of the right side of the mandible. The TFD must be 36 inches.
5. Set the kilovoltage switch to 65 kVp.



278.46
Figure 7-16.—Positions of patient, film, and central beam for a zygomatic view.



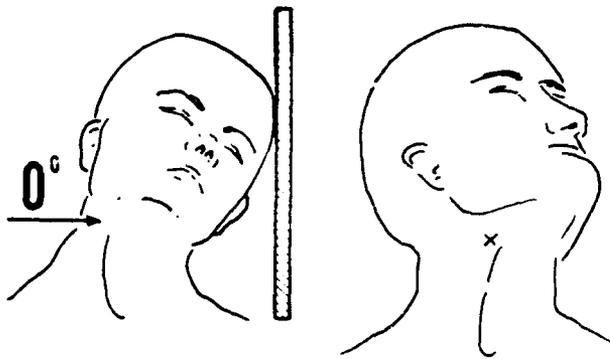
278.42
Figure 7-17.—Positions of patient, film, and central beam for a right lateral oblique view.

6. Set the milliamperage switch to 10 mA.
7. Set the exposure timer on 1/3 second (20 impulses).
8. Expose the view.

The procedure for exposing the left lateral oblique view are the same as those above, except that the left side of the patient's head is against the film cassette and the x-ray beam is directed under the right side of the mandible and at the middle of the left side of the mandible (figure 7-18). Exposure parameters are the same as for the right lateral oblique view.

TEMPOROMANDIBULAR JOINT VIEW

The dental officer will request a temporomandibular joint (TMJ) view when looking for a



278.43

Figure 7-18.—Positions of patient, film, and central beam for a left lateral oblique view.

fracture of the condyloid process, the articulation of the TMJ, the glenoid fossa of the skull, subluxation (partial dislocation) movement of the head of the condyloid process, or the appearance of a bone spicule. There are four different TMJ positions: the right joint (open and closed) and the left joint (open and closed).

To expose the right TMJ view, perform the following procedures:

1. Set an 8 × 10 inch cassette sideways in the wall-mounted cassette holder.
2. Adjust the stool. When the patient is seated, the right side of the patient's head must be directly in front of the cassette.
3. Position the patient as shown in figure 7-19. Touch the patient's right ear against the cassette, keeping the head parallel to it. The chin must be parallel to the floor.
4. Position the tubehead. Use a 2 × 2 inch cardboard square to locate the point 2

inches behind and above the left TMJ (figure 7-19). Set one corner of the square directly on top of the left joint; the opposite corner is the point you are to locate. Position the tubehead so that the central x-ray beam is directed at that point (which is the right TMJ), and the TFD is 15 inches.

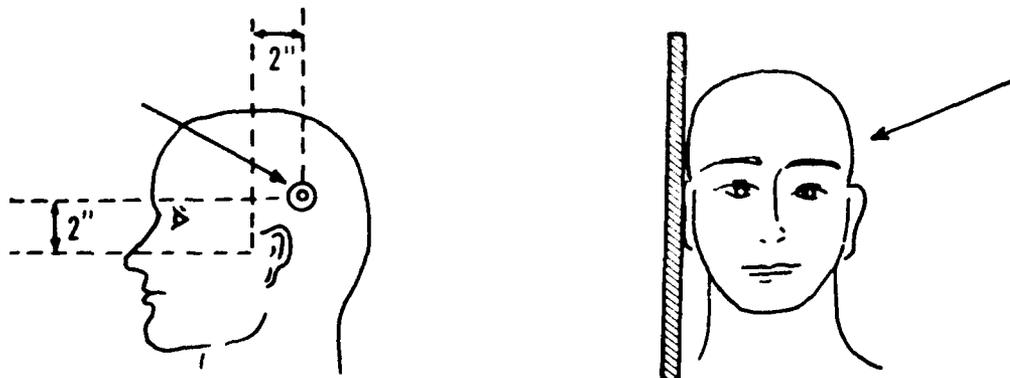
5. If the dental officer requested an open TMJ view, instruct the patient to open his mouth as wide as possible. For a closed TMJ view, have the patient's mouth closed tightly, with opposing teeth in normal occlusion.
6. Set the kilovoltage switch to 65 kVp.
7. Set the milliamperage switch to 10 mA.
8. Set the exposure timer to 1/2 second (30 impulses).
9. Expose the view.

To expose the left TMJ view, simply reverse the sides and follow the same procedures.

EXTRAORAL FILM PROCESSING

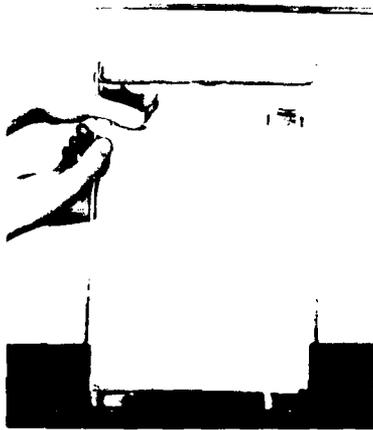
Extraoral radiographs are processed in the same manner as intraoral radiographs. Because of the relatively small size of dental processing tanks, developing solutions may quickly become weaker when large numbers of 8 × 10 inch extraoral films are processed. If such is the case, use a developer replenisher to help prolong the life of the solutions.

As mentioned earlier, you must remove exposed extraoral film within the darkroom under safelight conditions. Handle only the extreme edges of the film with your fingers. Once you remove the film from the cassette, feed it into the automatic developer. If your activity's automatic developer is not large enough to develop 8 × 10



278.47

Figure 7-19.—Positions of patient, film, and central beam for a temporomandibular joint (TMJ) view.



278.49
Figure 7-20.—Placement of an extraoral film on a rack for processing.

inch films, attach the film to a processing rack. Figure 7-20 shows a rack that has four clamps to secure the film. Because exposed extraoral film is somewhat sensitive to safelight illumination, process the film promptly after removing it from the cassette.

For legal purposes, each processed radiograph must contain the patient's name and social security number and the date of the exposure. If radiopaque letters and numbers were not attached to the film cassette, an identification printer may be used to mark the film before processing. You can also use white ink to enter the information on the processed radiograph, or an adhesive-backed label may be attached to the radiograph. Once it is processed and labeled, place the

radiograph in an envelope labeled with all the pertinent information concerning the film.

SUMMARY

Extraoral views are important diagnostic aids when examining the bones of the head and neck. As an advanced dental assistant, you may be required to expose and process such views. When using a conventional dental x-ray unit, ensure that it is equipped with a short tubehead cylinder. A cephalometric unit, if available, should be used to produce skull projections for the orthodontist and the oral surgeon. The fixed position of the tubehead and the cephalostat on the cephalometric unit enable you to achieve consistent, accurate results.

The usual method of exposing extraoral views employs screen films. Such film requires the use of film cassettes and intensifying screens. Although available in several sizes, 5×7 inch and 8×10 inch screen film is most commonly used in dentistry. You must handle screen film carefully to avoid damage due to pressure, contamination, and friction. Handle the sheet of film with your thumb and forefinger, grasping only the extreme edges.

Extraoral views (especially skull projections) require patience, attention to detail, and practice to produce satisfactory results. When exposing the views, ensure that the patient, the film cassette, and the x-ray tubehead are properly positioned. Process the radiographs promptly and be sure to label each exposed film with the patient's name and social security number, and the date of exposure.

CHAPTER 8

TRAINING

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the objectives and requirements of the inservice training program.
2. Identify instructional planning and development requirements.
3. Identify effective oral presentation techniques.

Training your personnel is one of the most important challenges you face as a senior dental technician. Whether in a formal school, a formal training program, or on the job, you are an instructor. You can expect top performance from your personnel only if their knowledge and skills meet the requirements of their billets. The better trained they are, the more productive they will be.

This chapter discusses the objectives and requirements of the inservice training program as set forth by higher authority. It covers the planning and development of a training situation using the systems approach to training. And, finally, it outlines various instructional methods and techniques. This chapter, however, is intended only as a guide. You, as the instructor and senior petty officer, must be thoroughly familiar with your command's training requirements. You must understand the various teaching methods and select the one most suited to your training situation.

INSERVICE TRAINING

The primary objective of training in the Navy is to ensure the combat readiness of all personnel. To this end, the Commander, Naval Medical Command, sets forth in **NAVMEDCOMINST 1510.2** series the policy and guidelines for inservice training of dental technicians. A comprehensive inservice training program must be conducted for all dental technicians in pay grades E-1 through E-6. As an organized, scheduled, and mandatory program, inservice training is conducted within a command during normal working

hours. Intended to be an extension of basic "A" school, it provides technicians with professional and technical knowledge to enhance their job performance and advancement opportunities.

TRAINING OFFICER DUTIES

As an advanced dental assistant, you may be appointed as the command's training officer. As such, you are responsible for program development, organization, and administration. Your duties may be to:

- Develop an annual inservice training plan.
- Prepare lesson plans and training guides.
- Maintain a resource library of books, manuals, and directives to be used as standard references for lesson development and presentation.
- Select and appoint instructors from the command or other Navy Medical Department activities. Select an instructor on the basis of (1) subject matter expertise, (2) communication skills, (3) military appearance, (4) attitude, (5) support of training requirements and goals, and (6) demonstrated skills as an instructor and leader.
- Schedule classes that are flexible and frequent to allow maximum participation.
- Ensure that each instructional presentation is appropriate in subject matter, content, and methodology.

- Monitor attendance and ensure that complete and accurate training records are maintained.
- Ensure that a training record is maintained for each enlisted member participating in the program. Records must be kept current and, as a minimum, include dates of instruction, lesson topics, contact hours, and performance tests completed. Records must be sufficient to satisfy requirements for service record entries.
- Ensure that service record entries are made, as appropriate, when training is completed or upon the member's transfer.

The exact nature of your activity's inservice training program is dictated by the activity's mission, dental technician rating requirements, and current personnel training levels. As mentioned earlier, Occupational Standards describe the Navy's minimum requirements for skills in specific rates and ratings. Use these standards as a basis for training. Recommended training objectives and resource materials supporting the occupational standards are listed in enclosure (2) of **NAVMECOMINST 1510.2** series. Designed as a guide for training officers, these training objectives should be used whenever possible to develop your training presentations. A bibliography for the program is also an enclosure to the directive. Use these publications to develop your training program and presentations.

The success of any inservice training program depends on careful planning. To be effective, each lesson must be well thought out and properly scheduled. When developing lesson plans and setting up schedules, remember that the larger the volume of information, the more time your people will need to absorb it. The speed at which people learn varies, though given enough time and practice, anyone should be able to learn any skill. Systematic training enables you to greatly reduce the time required for your personnel to learn necessary skills. With careful planning you can ensure that your personnel are taught what is required to perform their jobs. Scheduling ensures that adequate time is allowed for the necessary training.

INSTRUCTIONAL PLANNING AND DEVELOPMENT

This section outlines the approach for developing an instructional presentation, but it can also

be used to set up a training program. It is designed to familiarize you with basic instructional principles, and proceeds through a series of steps.

Careful planning cannot be overemphasized. Determine personnel training needs and plan training to meet those needs. As you develop your training session, keep in mind the following questions:

1. What will be the end result of your training session? What physical or manual skills should the students master? What mental skills must be developed?
2. Who will be taught? What is their background? Do they possess different levels of knowledge, skill, or experience?
3. What approach best enables the students to learn?
4. How will you determine whether the students have learned (written test, performance demonstration, etc.)?

TASK ANALYSIS

To design and carry out effective training, you must first have detailed knowledge of the job. So you begin your instructional planning and development by analyzing job tasks—what we call task analysis. Task analysis provides the answer to the following questions:

1. What work elements (subtasks) make up the tasks? In what order must these elements be performed? Work elements are the step-by-step procedures required to complete a task.
2. Under what conditions must each task be performed? Conditions refer to on-the-job conditions that significantly influence task performance. These include tools, equipment, special job aids or manuals, kind and amount of supervision available, and environmental conditions.
3. To what proficiency or standard must each task be performed; i.e., how well must each task be performed.

Essentially, there are two steps to conducting a task analysis: data collection and data classification. Both steps are discussed in the following paragraphs. As the developer or instructor of a particular lesson or a particular segment of training, you can probably do the task analysis yourself. As a training officer, you may choose to delegate some task analysis duties.

Collecting Task Data

During this step of the task analysis, thoroughly research each task or series of tasks. Consult pertinent directives and task literature, interview appropriate personnel, and observe performance of tasks. Make notes, diagrams, and sketches; they will be useful when you classify the data collected and develop teaching points.

By consulting applicable directives, procedural manuals, and manufacturer's instructions, you can familiarize yourself with the task and determine correct procedures.

Interview personnel who have performed the task, who are performing the task now, and who supervise those who perform the task. They may be personnel at your activity or at another dental facility. During the interview, collect the following data:

- Frequency and duration of task performance.
- Conditions under which the task is performed.
- Cues that initiate task performance.
- Standards of task accomplishment.
- Elements that make up the task.
- Any safety precautions that must be followed before and during task performance.

Dental equipment repair technicians can be a valuable source of information for tasks that involve the use of equipment. They are familiar with equipment operation, maintenance, and handling requirements.

If practicable, observe task performance firsthand. Collect the same data as listed above for personnel interviews. Ask questions to obtain a better understanding of the task. Observe associated tasks, if any, and be sure to record all safety precautions. If you cannot make a firsthand observation, you might review instructional films depicting task performance. Films may be obtained from the Navy, the manufacturer, or other sources.

Once data collection is complete, you should know how the task is accomplished. Review your notes, diagrams, and sketches to ensure that the information is accurate. Obtain answers to any questions you may have, and ensure that you completely understand each task before you go on to the next analysis step.

Classifying Task Data

During this step of your task analysis, organize and carefully document the data you have collected. A task analysis sheet like the one shown in figure 8-1 is recommended to help you record

The figure shows a task analysis sheet form. At the top, there is a header section with several lines for text entry. Below the header is a table with four columns. The columns are labeled 'TASK', 'SUB-TASK', 'ELEMENTS', and 'NOTES'. The table is currently empty, with only the headers filled in.

TASK	SUB-TASK	ELEMENTS	NOTES

Figure 8-1.—Sample Task Analysis Sheet.

the task data. To organize the data, accomplish the following:

1. Assign a job title. Because you are planning the training of dental technicians, you can simply enter "Dental Technician" as the job title on the task analysis sheet. As a command training officer, you may design training programs for different rates within the rating or the different rating specialties. Examples of these job titles are: Dental Technician, Basic; Dental Technician, Advanced; and Dental Equipment Repair Technician.
2. Assign a unit title. This title concerns the general area of instruction and normally identifies a job function that consists of a number of tasks. Some examples are: Oral Exam Assisting, Panoramic Radiographic Procedures, and Basic Life Support.
3. List all tasks, elements, conditions, and standards that relate to the unit title or job function. (Refer to your data collection notes.) In the "Notes" column you might include helpful information e.g., references, reminders, frequency of task performance. Ensure that your task analysis sheet is complete. Include all tasks that relate to the job function and, if necessary, list all elements in order of performance.

DEVELOPING LEARNING OBJECTIVES

Once you have completed the task analysis, you can determine just what it is you need to teach. Assume that you are to teach your personnel to take an accurate oral temperature. How will their performance be judged? What information or knowledge must they have?

These questions can be answered in one statement called a learning objective. A learning objective is an instructional goal expressed in behavioral terms. It states exactly what your personnel should be able to do after receiving instruction.

All learning objectives contain three essential elements: a statement of the *behavior* for performance expected as a result of training; the *conditions* under which the behavior is to occur; and the *standards* by which the behavior will be evaluated. These elements help make an objective communicate an intent.

The behavior element of a learning objective identifies what the student will do to demonstrate what has been learned. When you write the objective, ensure that the behavior is observable and that the objective states exactly what your personnel will be expected to do.

The conditions are factors that either limit nor aid personnel in performing the behavior. Limiting conditions set restrictions on performance. Aiding conditions provide help or assistance in the performance of the behavior. Examples of conditions are: the tools and equipment your personnel must use, special aids or manuals, environmental or weather conditions, and special physical demands. Determine conditions on the basis of your task analysis data and the training setting. Examples of conditions are indicated in italics in the following items:

1. Add a column of numbers *using a calculator*. . .
2. Type a letter, *given a 200 word rough draft*. . .
3. Don a life jacket *in a darkened room*. . .

Standards specify the level of proficiency which demonstrated behavior must meet. Standards are stated in terms of *how well* a student must perform the behavior on the job and are usually expressed in terms of completeness, accuracy, or time. You can often determine your standards from your task analysis data. Examples of standards are indicated in italics in the following items:

1. Add a column of numbers using a calculator *without error*.
2. Type a letter, given a 200 word draft. *Format must be correct as outlined in the Department of the Navy Correspondence Manual*.
3. Don a life jacket in a darkened room *in 3 minutes*.

Terminal Objectives

A terminal objective is a statement of final outcome. It describes the behavior, performance conditions, and the standards expected of the student upon completion of the training session.

By following the above learning objective guidelines, you can develop a terminal objective from the task you are to teach; e.g., "take an oral temperature." Divide a blank sheet of paper into three columns. Label one column "Behavior,"

another column "Condition," and the final column "Standard." Refer back to your notes from the task analysis to determine the three elements of the learning objective. When finished, your sheet may look like this:

<u>Behavior</u>	<u>Condition</u>	<u>Standard</u>
Take an oral temperature	Given a clinical oral thermometer and a patient and follow the correct sequence	Temperature reading must be within 0.2° of accuracy of procedure.

Now you can write the terminal objective:

Given a clinical thermometer and a patient in a health care setting, the student will take an oral temperature within 0.2° of accuracy, following the correct sequence established in the training manual.

The objective leaves no doubt as to what is expected. It also provides a basis for developing your training session.

Enabling Objectives

Now ask yourself, "What must I teach to achieve the terminal objective of the training session?" Outline your ideas on paper. Consult the task analysis sheet; the element of the task will often describe the skills the students need. But you must also determine what knowledge is necessary for task performance. Your outline may look like the following:

1. Why do we take temperatures?
2. What factors affect body temperature?
3. What terminology needs to be defined?
4. What is the average oral temperature?
What is the normal range?
5. What does an oral thermometer look like?
How does it work?
6. What are the contraindications to taking an oral temperature?
7. How do you take an oral temperature?

Next, put your outline into the format of an objective. This enables you and your students to know exactly what is expected. Because these objectives enable students to know exactly what is expected. Because these objectives enable students to achieve the terminal objective, they are called enabling objectives. Again, you must be specific.

Here are some examples of enabling objectives for the above terminal objective.

1. List the five purposes for taking a temperature, without the aid of notes, as discussed in class.
2. Using text information, identify all five factors that affect body temperature and describe the effects of each without error.
3. Given a list of 10 terms related to body temperature, correctly define at least seven.
4. Given a list of 10 different body temperatures, identify those within the normal range without error.
5. Given an illustration of an oral clinical thermometer, correctly label its construction and calibration characteristics as discussed in class.
6. Given a list of seven conditions, choose the five that are contraindications to taking an oral temperature.
7. Given a clinical thermometer and a simulated patient, demonstrate the correct procedures for taking an oral temperature. The student must follow the sequence established in the performance checklist and obtain a reading that is accurate to within 0.2°.

ANALYZING READINESS AND BACKGROUND

You must know all about the personnel you will be teaching. Ask yourself these questions: Who will be taught? What is their background? Do they possess different levels of knowledge, skill, or experience?

Ideally, you would have personnel with identical backgrounds and the same intellectual skills, educational foundation, experience, motivation, and attitudes. Unfortunately, this is never the case. Intellectual capabilities vary greatly, as do experiences. Some people may have a genuine desire to learn, while others have little or no interest.

You can determine some of these factors by examining records, or by individual interviews and observation. If you are developing an entire training program, you may first want to give your personnel a pretest. The test helps you assess personnel entry level. By determining how much your personnel already know, you can better develop a training program or session to meet their needs.

SELECTING TEACHING STRATEGIES

At this point in your instructional planning and development, you now ask yourself, "What is the best way for the student to learn the material to be taught?" You already know the desired end results. As an instructional designer you must now decide how to achieve those results.

Good organization is your key to success. Organize your information and supplement it with training aids or other materials. Present the topic in a systematic and orderly manner so that upon completion of training, the student will know exactly how to perform the task.

As the designer you have already examined the topic and determined the vital points to be learned. Ask yourself: How can the student best master these vital points? Are limitations to the training set by time and facilities? Is the subject matter more theoretical or more practical? Is it straightforward or must it be derived at by logic? Is the topic naturally interesting to your personnel or must interest be generated? You as the instructor, must be at ease with the subject matter, analyze its importance, and select the best teaching method and setting.

Teaching Methods

There are a variety of teaching methods designed to allow for maximum learning. Know these methods so that you can select the one best suited to your learning objectives. Following are descriptions of various teaching methods and their recommended applications.

LECTURE METHOD.—The lecture method is the most commonly used method. It is normally used to teach knowledge-type subject matter and to supplement other methods of instruction.

Although the lecture method can save time when teaching a large group, it has one primary disadvantage: lack of instructor and student interaction. A true lecture is a one-way oral presentation by a speaker to an audience. Lectures tend to be ineffective, regardless of an instructor's public speaking skills. Pauses during a lecture for direct oral questioning help create interaction between the instructor and the student. And use of training aids and audiovisual materials can

improve the effectiveness of a lecture. Photographs, overhead transparencies, slides, videotapes, models, and chalkboard diagrams help hold student interest, thus increasing understanding and retention. If training time, facilities, and personnel numbers limit you to the lecture method, use your imagination. Make maximum use of oral questions, training aids, and audiovisual materials.

DEMONSTRATION METHOD.—In a skill-type learning situation you may want to demonstrate the performance steps for a given task. Explain the reason for each action as you give a demonstration but plan well to avoid leaving out important explanations or steps. The sequence of the performance steps is usually important and must be carefully considered when you plan your presentation.

If you will be demonstrating before a large group, or if viewing is difficult because the equipment is small, use enlarged devices or training aids. Whenever possible, give the student an opportunity to repeat the procedure in a hands-on practice session. This reinforces learning. Because you supervise the practice, you can immediately correct errors and reinforce the proper procedure. This speeds the learner's achievement of the objective. Demonstration is an effective teaching method.

DISCUSSION METHOD.—The discussion method can be effectively used to get students to think constructively while interacting with others in a group. Students have the opportunity to observe, listen, and actively participate in meeting objectives. Although discussions can be conducted with both large and small groups, small groups (15 people or less) are more desirable. An extremely large group may be broken into smaller groups or teams, with a discussion leader for each.

There are three modes in the discussion method: students discussing a subject without direction from an instructor, and instructor-directed and controlled discussion between experts, with or without student interaction.

COMBINED METHODS.—You can also use a combination of the above methods. Your approach depends on your creativity, the availability

of materials and facilities, and the personnel you are to train. Case studies are thought provoking and helpful for discussions and raising critical issues. Demonstration is useful in illustrating physical activity.

Recall the terminal and enabling objectives for our earlier example: taking an oral temperature. How could this material be presented so that it is effective, varied, and appropriate? You might use the lecture method (maybe using overhead transparencies) to teach the five purposes for taking a temperature. The demonstration method could be used effectively to teach techniques of taking an oral temperature, or you could use films or videotapes.

MEASURING LEARNING

Measuring learning is vital for feedback. As the instructor you must know how well students perform. Students, in turn, must know at what level they are performing. Provide students with continuous feedback to let them know if they really understand the material. You can measure learning formally through graded tests, or informally through quizzes, question-and-answer periods, or observation of practical application of the material.

You have already developed your learning objectives. To measure learning you can rewrite those objectives as test items. This way you can ensure that you use the same standards you first set for learning. This is called a criterion-referenced test.

Developing a Test

Several considerations must be kept in mind when developing a criterion-referenced test. First, review all learning objectives to ensure that they are complete, definite, and clear. Students must know exactly what is expected of them. For example, the objective "Given a clinical thermometer and a patient in a health care setting, the student will take an oral temperature within 0.2° of accuracy, following the sequence established in the performance checkoff list" is much clearer than "The student will take a temperature."

Second, stick to your objectives. Test practical applications only if they have been taught. Test

learners only on material that has been covered in the presentation. An individual test item must be directly traceable to the specific objective it measures.

Third, establish a scoring system based on the learning objective standard. If the standard is 100 percent, as in "Identify all five factors that affect body temperature and describe the effects of each," identifying and describing only four factors would not suffice. All students have the same requirements and must be graded on the same criteria.

Use your tests not only to evaluate learning, but also to evaluate the quality of the training. If students consistently fail to meet a learning objective, you must reevaluate the objective, revise the instructional material or the test, or recognize the need for prerequisite skills. This keeps teaching pertinent and appropriate to those you are training.

The two major categories of criterion-referenced tests are described below.

PERFORMANCE TESTS.—Performance tests are used to measure learning objectives that require actual performance of a certain task, such as removing sutures. The two types of performance tests commonly used are the checklist and the final product test.

The checklist performance test requires the student to perform, in sequence, a procedure that has well-defined steps. The test administrator uses a form that lists all the steps in sequence. Across from each step or item, a check is placed in the "Yes" or "No" block to indicate performance. Comments can be added as necessary to describe the student's weaknesses or errors. To help determine the criteria for pass-fail, certain steps may be classified as critical. Failure to demonstrate those steps constitutes failing the test; e.g., failing to read the thermometer accurately. This type of test item is recommended for skill-oriented tasks that are critical, complex, or lengthy.

The other type of performance test is composed of final product test items. Here, the importance lies with the end result rather than the process used to reach it. This type of testing might be used to direct a student to make a postoperative bed. It may not be important if one side of the

bed is completed before the other is started or if the student runs from side to side. The major concern is the final product.

WRITTEN TEST.—When use of performance tests would be too costly, dangerous, or impractical, use written test items. There are five types of written test items: completion, multiple-choice, matching, true-false, and labeling.

Completion Test Items.—For a completion test (fill-in-the-blank) item, the student must provide the answer rather than select one. When you construct a completion item, leave only one blank per sentence. Ensure that only *one* correct answer will fit. The blank should appear at or near the end of a sentence. The missing part must be important, not trivial. Some examples are:

1. Exercise may cause body temperature to _____. (*increase*)
2. A thermometer with a long, slender bulb is used for taking a/an _____ temperature. (*oral*)

Multiple-Choice Test Items.—Use multiple-choice test items primarily to determine the student's ability to recall facts and principles. The student must select the correct response, rather than provide it. Design the question so only one answer is correct. Develop four or five answer choices for each question. Ensure that only one is clearly correct and that the others (distractors) are plausible. Use pictures or diagrams if they represent the situation better than words. Try to avoid negative terms, unimportant details, or choices such as "all of the above." Some examples are:

1. The "normal" or average oral temperature is
 - *a. 98.6°F
 - b. 99.2°F
 - c. 99.6°F
 - d. 100.1°F

2. The most accurate method of taking a temperature is
 - a. oral
 - *b. rectal
 - c. axillary

Matching Test Items.—Matching test items can be used when testing a student's ability to identify, associate, and discriminate among similar or related items. Match words, phrases, pictures, or values. For example, you might use a diagram of the heart with numbered parts, and a separate lettered list of the parts may be matched by the student being tested. Another method is to list terms on one side and definitions on the other, as in the following example:

- | | |
|------------------------|-------------------------------|
| a. 1. Body temperature | a. Balance of heat maintained |
| c. 2. Fever | between production and |
| d. 3. Febrile | loss |
| b. 4. Afebrile | b. Without fever |
| | c. An elevated body |
| | temperature |
| | d. Having fever |
| | e. Lowered body temperature |

Usually one of the columns is an item or two longer, and not all items need to be used. This is perhaps the easiest type of question to formulate.

True-False Test Items.—The fourth type of written test item is the true-false item. Because a guess by a student has a 50 percent chance of being right, you must take care when you develop a true-false question. Avoid using negatives, absolutes, or generalities such as "some," "any," or "generally." Some good examples are:

1. T x F _____ An oral thermometer should be left in place for 3 minutes.
2. T _____ F x _____ Mouth breathers should have oral temperatures taken.

Labeling Test Items.—The last test item is the labeling item. The student identifies certain parts

UNIT TITLE: Oral Examination Assisting	TERMINAL OBJECTIVE
LESSON TITLE: Taking Temperatures	Given a clinical thermometer and a patient in a health care setting, the student will take an oral temperature within 0.2° of accuracy, following the correct sequence established in the performance checklist.
ALLOTTED LESSON TIME: 2.5 Contact Hours 1.0 Classroom 1.5 Practical	
INSTRUCTIONAL MATERIALS	ENABLING OBJECTIVES
References	1. Without the aid of notes, list the five purposes for taking a temperature as discussed in class.
Gragg SH, Rees OM: <u>Scientific Principles in Nursing</u> , ed 5. St Louis, CV Mosby Co, 1970, chs 16, 17, and 18.	2. Using text information, identify all five factors that affect body temperature and describe the effects of each with 100% accuracy.
Nichols GA, Verhonick PJ: "Time and Temperature" <u>Am J Nurs</u> . 67:2304-2306, 1967.	3. Given a list of 10 terms related to body temperature, correctly define at least seven.
US Navy: <u>Nursing Procedures Manual</u> , NAVMED P-5066, 1980.	4. Given a list of different body temperatures, identify those within the normal range with 100% accuracy.
Training Aids	5. Given an illustration of an oral clinical thermometer, correctly label each of the construction and calibration characteristics as discussed in class.
Oral, rectal, electronic thermometers and care tray.	6. Given a list of seven conditions, choose the five that are contraindications to taking an oral temperature.
TPR log	7. Given a clinical thermometer and a simulated patient, demonstrate the correct procedure for taking an oral temperature. (The student must follow the sequence established in the performance checklist and obtain a reading that is accurate to within 0.2°.)
Transparencies	
Videotape (taking an oral temperature)	
Note-taking sheet.	
	TESTING INSTRUMENTS
	1. Written test (varied items)
	2. Performance test

Figure 8-2.—Lesson topic guide cover page.

of a picture or diagram. For example, the anatomy of the heart or parts of a thermometer might be illustrated. The student labels the particular parts indicated.

DEVELOPING INSTRUCTIONAL MATERIALS

Now that you have developed your plan for teaching, you are ready to develop instructional materials. Such materials must include a lesson topic guide and may include student handouts and training aids. Following are descriptions and preparation procedures for each.

The Lesson Topic Guide

A lesson topic guide (LTG) is an organized outline of a single lesson topic. It serves as an instructor's blueprint of what is to be accomplished in a class. Complete and detailed, the LTG lists:

- References
- Training aids

- Class objectives
- Main teaching points
- Methods and procedures
- Supplemental information as needed

An LTG ensures coverage of the subject matter and serves as a timetable for class completion. Following are descriptions of the LTG elements and format.

LTG COVER PAGE (figure 8-2).—This is a two-column page containing the following information:

Unit Title.—As the general area of instruction, this title identifies a job function that consists of a number of tasks. It is the same as the title shown on the task analysis sheet.

Lesson Title.—As the specific area of instruction, this title identifies the subject matter to be covered in the lesson. Examples include: Operating Panoramic X-ray Equipment, Dental Instruments in Operative Dentistry, and Mouth-to-Mouth Ventilation.

Allotted Lesson Time.—Enter the time allotted for completion of the individual lesson. Classroom and practical application periods are listed as necessary.

Instructional Materials.—List the materials that the instructor or student may use before or during the presentation. Include all source materials or references used to gather information to support the learning objectives. Also list instructional aids such as equipment and training aids.

Lesson Objectives.—Give the terminal and enabling objectives for the lesson.

Testing Instruments.—Identify the written and/or performance tests to be used to determine the student's achievement of lesson objectives.

Outline Page(s) (figures 8-3A and 8-3B).—This is a three-column page containing the following:

Outline of Instruction.—In this column include all major points to be covered, giving enough detail so that the LTG can be used as the primary teaching document. You can use sections from textbooks, descriptive phrases, or key words, but keep it in outline form. In the introduction include reminders to introduce yourself, your

OUTLINE OF INSTRUCTION	INSTRUCTOR ACTIVITY	STUDENT ACTIVITY
<p>I. Introduction to the lesson</p> <p>A. Establish contact</p> <p>B. Establish readiness</p> <p>C. Establish value</p> <p>D. Overview</p> <p>II. PRESENTATION</p> <p>A. Definitions</p> <p>1. Thermometer...an instrument used to measure temperature</p>	<p>Expand the Outline of Instruction by explaining, making contrasts, giving examples, and discussing the materials so that feedback is positive.</p> <p>1. Introduce self</p> <p>2. Prepare students</p> <p>a. Identify lesson</p> <p>b. Give a general overview</p> <p>3. Explain value of lesson</p> <p>a. To select correct method</p> <p>b. To take temperature accurately</p> <p>c. To identify effects of various factors and conditions</p> <p>d. To identify norms</p> <p>4. State lesson objectives</p> <p>a. Identify lecture modes</p> <p>b. Identify practical labs</p> <p>5. State information necessary to guide student conduct</p> <p>a. Notes</p> <p>b. Questions</p> <p>c. Testable information</p> <p>Write terms on chalkboard</p>	<p>Take notes. Follow note-taking sheet.</p> <p>Take notes. Follow note-taking sheet.</p>

Figure 8-3A.—Lesson topic guide outline page.

to see the outline of the lesson and record all pertinent information. They are particularly useful for lessons that present difficult or complicated material. A sample note-taking sheet is shown in figure 8-4. No matter how you format the sheet, be sure to include the main points of the lesson and to leave enough space for the students to fill in some notes of their own.

Job sheets provide the students an opportunity to move step by step through a detailed procedure. It lists all required equipment and materials and any necessary precautions. If necessary, you can include self-test items and even instructor verification. A sample job sheet is shown in figure 8-5.

Training Aids

Use training aids to supplement the main points presented in the lesson. They help to focus attention, develop understanding, and make the subject matter more vivid. The following types of training aids are frequently used in presenting a lesson:

- Actual equipment (the best training aid when practical).
- Mockups (used when actual equipment is unavailable, too costly, or too dangerous for demonstration).

<p>NOTE-TAKING SHEET</p> <p>Taking Temperatures</p>
<p><u>REFERENCES</u></p> <p>Gragg SH, Rees OM: <u>Scientific Principles in Nursing</u>, ed 5. St. Louis, CV Mosby Co, 1970, chs 16, 17, and 18.</p> <p>Nichols GA, Verhonick PJ: "Time and Temperature" <u>Am J Nurs.</u> 67:2304-2306, 1967.</p> <p>US Navy: <u>Nursing Procedures Manual</u>, NAVMED P-5066. 1980.</p>
<p><u>NOTE-TAKING OUTLINE</u></p> <p>I. Definitions</p> <p>A. Thermometer:</p> <p>B. Body Temperature:</p> <p>1. Production</p> <p>2. Loss</p> <p>C. Fever:</p> <p>D. Febrile:</p> <p>E. Afebrile:</p> <p>II. Purposes for Taking Temperature</p> <p>A.</p> <p>B.</p> <p>C.</p> <p>D.</p> <p>E.</p> <p>III. Factors Influencing Temperature</p> <p>A.</p> <p>B.</p>

Figure 8-4.—Sample note-taking sheet.

TECHNIQUES OF ORAL PRESENTATION

The techniques of oral presentation apply not only to lectures, but also to other presentations where oral explanations play a secondary but important role. Oral instruction is generally necessary to give information, to arouse attention and interest, and to develop receptive attitudes on the part of the students. Listed below are some basic guidelines for effective oral presentation.

1. Maintain good eye contact. As you speak, shift your gaze about the class, pausing momentarily to look at each student. Make the students feel that what you have to say is directed to each one personally. Your eyes as well as your voice communicate a message to them; and their eyes, facial expressions, and reactions communicate to you. Watch for indications of doubt, misunderstanding, desire to participate, fatigue, or lack of interest.
2. Maintain a high degree of enthusiasm.
3. Speak in a natural, conversational voice. Enunciate your words clearly. Make certain that the student can hear every word.
4. Emphasize important points by the use of gestures, repetition, and variation in voice inflection.
5. Check student comprehension carefully throughout the presentation by watching faces and by asking questions. Observing facial expressions as an indication of doubt or misunderstanding is not an absolutely sure way of checking student comprehension. Some students may appear to be comprehending when, in reality, they are completely confused. Students who are in doubt often hesitate to make their difficulty known.

Frequently ask for questions from the class. This provides the students an opportunity to indicate any doubts or misunderstanding. Your personal knowledge and past experiences should enable you to ask specific questions concerning troublesome areas. Don't make the mistake of waiting until the end of the presentation to ask questions. The best time to clear away mental fog is when the fog develops.

6. Instruct at the class level. Use words, explanations, verbal illustrations, and questions that the average student in class will

understand. Technical words must be explained.

7. Stimulate the students to think. Here the word "think" refers to creative thinking rather than to mere recall of facts previously learned. Use instructional devices to stimulate student thought: thought-provoking questions, class discussions, problem situations, challenging statements, and rhetorical questions (questions to which no answer is expected). Another device is to use suggestions such as "I want you to think along with me" and "consider your reaction to this situation."
8. And, finally, if you are using a training aid such as a chalkboard, be sure to turn your head toward the students when you talk.

No matter how well you have planned and developed your lesson, you face the real test when you actually present it to the students. Follow the guidelines above. All your preparation will have been in vain if you cannot communicate with the group.

SUMMARY

Training must be planned, scheduled, and evaluated. The plan identifies the skills to be taught and the time, materials, and resources required to teach them. The schedule identifies when and where the training will take place, who will teach, and who will be taught. The evaluation is used to determine if the training was successful.

As a senior dental technician you are an instructor. Whether developing a complete inservice training program or an individual training session, you must carefully plan in order to succeed. Thoroughly analyze the task(s) you are to teach, develop learning objectives, analyze your students' readiness and background, select an appropriate teaching method, and develop a method to evaluate learning. And, finally, develop instructional materials, keeping the learning objectives and your students in mind.

REFERENCES

NAVMEDCOMINST 1510.2 series, *Inservice Training for Hospital Corpsmen and Dental Technicians*, January 1984

NAVEDTRA 10046, *Military Requirements for Petty Officer First Class*, Chapter 6

NAVEDTRA 110A, *Procedures for Instructional Systems Development*

NAVEDTRA 106A, Phases I-V, *Interservice Procedures for Instructional Systems Development*

NAVEDTRA 107, *A Manual for Navy Instructors*, Chapters 3-7

A Handbook for Preparing Teaching Materials, Naval Health Sciences Education and Training Command

CHAPTER 9

ADMINISTRATIVE ESSENTIALS

Learning Objectives

Upon completion of this chapter you will be able to:

1. Recognize the contents and maintenance requirements of official publications.
2. Identify the requirements and procedures of the Navy filing system.
3. Identify records disposal requirements and procedures.
4. Identify the types, contents, and uses of naval correspondence.
5. Identify recommended correspondence management practices.

As you advance to the senior dental technician level, your administrative duties will increase. You may provide administrative support for a shipboard dental department—or for an entire dental command.

Therefore you must be familiar with official publications and directives and with office practices (filing, records disposal, correspondence, etc.). This chapter will give you a strong basic knowledge of these requirements. For detailed instructions consult the appropriate publication or directive.

OFFICIAL PUBLICATIONS

Your familiarity with official publications and directives will enable you to give definite and immediate answers to questions that arise daily. You are not expected to know all the answers, but you should know where to find them. In this chapter the term “official publications” is used to include books, manuals, and directives issued by all levels within the Department of the Navy and DOD. They set forth precise procedures, policies, and directions.

Official publications can be obtained through normal supply channels, except those issued through the directives issuance system. The *Navy Stock List of Forms and Publications*, NAVSUP P-2002, provides directions for ordering publications. Directives are ordered from the Naval Publications and Forms Center, Philadelphia,

PA, using Departmental-Directives Requisition, NAVSUP Form 1205.

You must ensure that your files of publications and directives are current. An out-of-date publication is worthless. Make all required changes and corrections as described later in this chapter. When you receive a list of effective pages, check the pages of your copy of the publication against the list. This determines if your copy is current.

Some of the most commonly used publications are described below.

U.S. NAVY REGULATIONS

The *United States Navy Regulations* (NAVREGS) is the principal regulatory document of the Department of the Navy. It outlines the organizational structure of the Department of the Navy and issues the principles and policies by which the Navy is governed. It sets forth the responsibility, purpose, authority, and relationships of each bureau and office of the Navy Department; the rights and responsibilities of persons in the Department of the Navy; and procedures for rendering honors and conducting official ceremonies. It is published in loose-leaf form and kept in an adjustable binder so changes may be inserted easily.

STANDARD ORGANIZATION AND REGULATIONS OF THE U.S. NAVY

Standard Organization and Regulations of the U.S. Navy, OPNAVINST 3120.32 series, sets

forth regulations and guidance governing the conduct of all U.S. Navy personnel. Two type styles are used: italics for regulatory (violations punishable under the UCMJ); plain type for guidance of commanders, *commanding officers*, and officers in charge. You should be familiar with the entire publication, especially when serving aboard ship. Of particular interest to you are these chapters: Chapter 3 (Unit Organization), Chapter 5 (Regulations), and Chapter 6 (Unit Bills).

MANUAL OF THE MEDICAL DEPARTMENT

The naval publication of most interest to you as a senior dental assistant is the *Manual of the Medical Department (MANMED)*, **NAVME P-117**. It serves as a guide for the administration of the Medical Department, establishing both mandatory regulations and nonregulatory guidelines. It is published in loose-leaf form for convenience in inserting changes.

You should have a good overall knowledge of **MANMED** and a thorough knowledge of the following chapters:

Chapter 1—outlines the organizational structure of the Navy Medical Department.

Chapter 6—provides the basic source of information for all dental matters. It contains information essential for the proper functioning of any dental facility.

Chapter 15—specifies physical requirements and standards to qualify for specific types of duty.

Chapter 16—covers contents, opening, closing, and custody of health records.

NAVAL MILITARY PERSONNEL MANUAL

The *Naval Military Personnel Manual (MILPERSMAN)* contains instructions governing Navy personnel administration: personnel procurement, enlistments and reenlistments, personnel distribution, leave and liberty, etc. You should be familiar with the preface and the table of contents.

This manual uses a seven-digit number to identify chapter (first two digits), section (second two digits), and article (last three digits). This seven-digit-number is referred to as the article number, but it actually includes chapter, section, and article numbers. Though the digits are written

together, an article number is spoken as three separate groups of numbers (e.g., 38 60 280).

Changes are issued quarterly, reaching holders during the first month of each quarter. They are identified by the month of distribution and calendar year (e.g., 1/87, 4/87, 7/87, 10/87).

MANUAL OF ADVANCEMENT

The *Manual of Advancement, BUPERSINST 1430.16* series, published by the Chief of Naval Personnel, provides for the administration of the advancement system for enlisted personnel, as outlined in **MILPERSMAN**. Commonly referred to as the Advancement Manual, it provides instructions for determining eligibility requirements; preparation of forms; ordering, custody, and disposition of Navy-wide examinations; administration of advancement exams; changes in rate or rating; and procedures for effecting advancements.

The Advancement Manual is divided into two sections. Section one concerns active duty personnel, and section two concerns members on inactive duty.

NAVY PAY AND PERSONNEL PROCEDURES MANUAL

The *Navy Pay and Personnel Procedures Manual (PAYPERSMAN)*, **NAVSO P-3050**, is issued jointly by the Chief of Naval Personnel and the Comptroller of the Navy. It contains directions for implementing changes to the automated pay and personnel system. You will commonly refer to the **PAYPERSMAN** when preparing optical character recognition (OCR) documents and verifying OCR service record pages.

ENLISTED TRANSFER MANUAL

The *Enlisted Transfer Manual (TRANSMAN)*, **NAVPER 15909**, is the official manual for distribution and assignment of U.S. Navy enlisted personnel. It supplements basic regulations and instructions issued in **MILPERSMAN**.

TRANSMAN provides a quick reference for instructions and information on enlisted distribution. Its intent is to reduce clerical workload, thus promoting administrative efficiency.

UNIFORM REGULATIONS

The *United States Navy Uniform Regulations, NAVPER 15665F*, describes occasions when

various uniforms should be worn; lists required uniforms and articles worn together; and gives methods of wearing medals, decorations, ribbons, rating badges, and special markings. It also provides recommendations on the care of your uniform.

The yearly change to this manual becomes effective the beginning of each fiscal year. Any change that requires immediate publication (referred to as an interim change) is issued by notice or message.

AWARDS MANUAL

The *Navy and Marine Corps Awards Manual*, **SECNAVINST 1650.1** series, provides information and guidance on authority to recommend and approve awards, order of precedence, and preparation of award recommendations.

MANUAL FOR COURTS-MARTIAL

By enactment of the *Uniform Code of Military Justice (UCMJ)*, Congress established a single set of laws for administering justice to all Armed Forces. Under the authority of the Constitution and the UCMJ, the President issued the *Manual for Courts-Martial (MCM), United States, 1984*.

The MCM contains a complete copy of the UCMJ, describes the types of courts-martial established by the UCMJ, defines their jurisdiction, and prescribes their membership and procedures. It also prescribes limitations on punishments and covers such matters as non-judicial punishment, review of court-martial proceedings, and new trials.

MANUAL OF THE JUDGE ADVOCATE GENERAL

The *Manual of the Judge Advocate General (JAGMAN)*, **JAGINST 5800.7** series, is prepared by the Navy Judge Advocate General and applies only to the naval service. It covers legal and judicial matters, and supplements the MCM in some areas. Included in the JAGMAN are instructions about boards of investigation and examining boards and their composition, authority, and procedures.

JOINT FEDERAL TRAVEL REGULATIONS

The *Joint Federal Travel Regulations (JFTR)* supersedes the *Joint Travel Regulations (JTR)*. The JFTR is issued in three volumes:

- Vol. 1 - covers travel of uniformed service members

- Vol. 2 - covers travel of federal civilian employees
- Vol. 3 - covers travel of Foreign Service officers

JFTR interprets the laws and regulations concerning travel, the manner in which transportation is furnished to personnel, travel of dependents, transportation of household goods, reimbursements for travel expenses, and related information.

NAVY TRAVEL INSTRUCTIONS

The *Navy Travel Instructions (NTI)* is issued jointly by the Chief of Naval Personnel, the Comptroller of the Navy, and the Commandant of the Marine Corps. It amplifies the rules laid down in Volume I of the JTR as they apply to the Navy and Marine Corps. In any case where instructions in NTI and JTR conflict, the JFTR takes precedence.

SECURITY REGULATIONS

The *Department of Defense (DOD) Information Security Program Regulation* and the *DOD Personnel Security Program Regulation* contain regulations for safeguarding classified material and for personnel security. Their provisions are applicable to all Department of Defense activities.

The *Department of the Navy Information and Personnel Security Program Regulation*, **OPNAVINST 5510.1** series, implements the DOD regulations within the Department of the Navy. Commonly referred to as the "Security Manual," its provisions apply to Department of the Navy military and civilian personnel. The Security Manual contains detailed instructions for classifying, marking, and handling classified information; prescribes policy and procedures for access to and disclosure of classified information and provides instructions for personnel security determinations.

STANDARD SUBJECT IDENTIFICATION CODES

The *Department of the Navy Standard Subject Identification Codes (SSIC)*, **SECNAVINST 5210.11** series, sets forth a single standard system of numbers for use throughout the Navy. These numbers are prescribed for use in subject classifying and identifying correspondence, directives,

and blank forms; assigning report control symbols to reports; setting up filing and retrieval systems; computer message routing; and for use with any other documents to which reference is made by subject.

CORRESPONDENCE MANUAL

The *Department of the Navy Correspondence Manual*, SECNAVINST 5216.5 series, defines naval writing standards and contains instructions for preparing letters, endorsements, and memoranda. It also gives directions for assembling correspondence for signature and mailing, and explains correspondence management practices. To avoid repetition, it gives no detailed instructions on directives, classification markings, and preparation of electrical messages. These are covered in SECNAVINST 5215.1 series, OPNAVINST 5510.1 series, and NTP 3. The Correspondence Manual is covered in more detail later in this chapter.

RECORDS DISPOSITION MANUAL

The *Navy and Marine Corps Records Disposition Manual* SECNAVINST 5212.5 series, establishes records retention standards and provides directions for record storage, retirement, transfer, and destruction. This manual is also discussed in greater detail later in this chapter.

STANDARD NAVY DISTRIBUTION LIST

The *Standard Navy Distribution List (SNDL)*, published by OPNAV, provides for the proper addressing and distribution of mail to all Department of the Navy activities. It also provides a central distribution system for directives and correspondence. It is issued as two separate publications:

Part 1—often referred to as the “yellow pages,” is entitled *Standard Navy Distribution List, Operating Forces of the Navy, Unified and Specified Commands, U.S. Elements of International Commands*, OPNAV PO9B2-107. The SNDL listings are identified by a two-digit number for each major group, followed by one or more letters for each subgroup. Further subdivision can be made by adding a numeral.

Part 2—contains the *Catalog of Naval Shore Activities*, OPNAV PO9B2-105. This is the official list, including echelon of command, of all

shore activities of the Department of the Navy. It gives the addresses and distribution requirements (number of copies of directives or publications is provided automatically).

The SNDL is reissued annually. Changes are of two types: page changes and serial changes. Serial changes are provided only to commands that handle large volumes of mail and require up-to-date information.

DIRECTIVES ISSUANCE SYSTEM

The *Department of the Navy Directives Issuance System (DIS)*, SECNAVINST 5215.1 series, provides a standard method of issuing directives by all Navy activities. It is a two-part manual:

Part 1, Definitions, Criteria, and Responsibilities, defines a directive as an instruction (order), notice (bulletin), or change transmittal that prescribes or establishes policy, organization, conduct, methods, or procedures. It establishes criteria and outlines responsibilities for issuing a document in the directive system.

Part 2, Preparation and Maintenance of Directives, provides instructions on the preparation of directives (content and format). The information is given in two tables: Table 1, Preparation of Letter-Type Directives, and Table 2, Preparation of Special-Type Directives. Part 2 also provides guidance on stocking, requisitioning, filing, maintaining, and disposing of directives.

Instructions are kept current by issuing either a change transmittal or a revision of the existing instruction in completely rewritten form.

Change transmittals are normally used to transmit changes to an instruction or, under special circumstances, a notice. They are numbered consecutively and give directions for making the change. To indicate that you have made a change, make a notation (e.g., CH-1) in the upper right margin of the first page of a directive. For a publication-type directive, make the notation in the Record of Changes.

A revised instruction retains the same subject and consecutive number as the one it supersedes. But a capital letter suffix is added immediately following the consecutive number (e.g., “A” for the first revision, “B” for the second revision, etc.).

CONSOLIDATED SUBJECT INDEX

The *Department of the Navy Directives Issuance System Consolidated Subject Index (CSI), NAVPUBNOTE 5215*, is issued twice a year by the Navy Publications and Printing Service. It lists instructions issued by Washington, DC headquarters organizations, and is a valuable aid in identifying active naval instructions applicable to programs, reporting requirements, and facility operations.

The CSI is divided into four parts. Part I is an alphabetical listing of instructions by subject. Part II is a numerical listing of instructions by sponsor and numerical sequence. Part III lists instructions recently canceled by their sponsors. Part IV is a cross-reference listing to assist activities requiring DOD directives.

NAVY REGISTER

The full title of the Navy Register is *Register of Commissioned and Warrant Officers of the U.S. Navy and Reserve Officers on Active Duty, NAVPERS 15018*. Published yearly, it is issued to all ships and stations. It contains an alphabetical listing along with a list by lineal numbers of all officers. A lineal number is assigned to each officer and establishes the officer's seniority within grade and corps.

A lineal number consists of a whole number and a subnumber. Subnumbers make it possible to add or take away names without renumbering the list. The system works inversely—the lower the lineal number, the higher the seniority. For example, an officer with a lineal number of 8939-40 is senior to an officer with the lineal number 8983-82; an officer with a lineal number of 8936-95 is senior to both.

NAVY FILING SYSTEM

As an advanced dental assistant, you must be able to file and quickly retrieve correspondence and related documents. You will be called upon to produce a certain piece of correspondence from your files. The time it takes to locate it depends to a large extent on how well you know the Navy filing system. The basis of this system is the SSIC discussed earlier.

Assume that a senior officer asks to see a certain letter concerning preventive dentistry. He recalls reading it approximately 6 months earlier and believes it originated in NAVMEDCOM.

With this information, you must locate the correspondence. A difficult task? Not if you are thoroughly familiar with the Navy's filing and coding system.

This section covers the requirements and procedures of the Navy filing system. Details of file arrangement within any activity depend on mission requirements and the volume of its official correspondence. The present system for assigning subject identification numbers ensures that uniform procedures are followed by all naval activities. This enables you to perform filing duties in future assignments as well as within your present activity.

FILE EQUIPMENT

It is unlikely that you will be called upon to set up an office by yourself, so you need no detailed knowledge of available equipment. But you should have a general knowledge of the types of filing equipment used in Navy offices.

Regular File Cabinets

The types and sizes of file cabinets vary to accommodate the size of the material filed. Because materials should be filed without folding, the size of the cabinet is determined by the size of the individual sheets, folders, cards, or other records filed. A file cabinet larger than necessary is a waste of space, materials, and money.

Noninsulated, letter-size steel cabinets are standard equipment in the Navy for active correspondence and documents. Use five-drawer cabinets whenever feasible. Four- and five-drawer cabinets require the same amount of deck space, but additional filing capacity and more efficient space utilization are obtained by using a five-drawer cabinet. Use legal size and other types of cabinets only when absolutely necessary.

File drawers are normally equipped with adjustable backstops known as compressors. These devices keep your files upright and orderly when a file drawer is only partially filled.

Security File Cabinets

The *Department of the Navy Information and Personnel Security Program Regulation, OP-NAVINST 5510.1* series, specifies security requirements for file cabinets used for classified material. Stated generally, only filing cabinets approved by the Federal Government as security filing equipment may be used. Until phased out, a

steel filing cabinet with a built-in, three-position, dial-type combination lock may be used to store Secret and Confidential material. As a last resort, a steel filing cabinet with a steel lockbar and a General Services Administration (GSA)-approved changeable combination padlock may be used for such material. Consult the Security Manual when a determination is needed on the security value of a file cabinet.

File Folders

Folders are used to keep your correspondence files neat and orderly. They are available in two sizes: letter (9×11-3/4 inches), and legal (9×14-3/4), and have tabs that project above the file. An identification label is generally placed on the tab.

Tabs are either straight-cut, i.e., extending the full length of the folder, or are cut in one of three positions: left, center, or right. The latter are often referred to as one-third cut tabs. Figure 9-1 shows an effective folder arrangement using one-third cut tabs. As you can see, they give an at-a-glance overview of a drawer's contents.

Folders are normally packed in boxes of 50 and are ordered by their tab positions. Estimate your immediate and future file folder requirements based on the volume of material to be filed, the number of file drawers available, and variety of your subject codes.

STANDARD SUBJECT CODES

The *Department of the Navy Standard Subject Identification Codes (SSIC)*, SECNAVINST 5210.11 series, contains numerical codes that provide the basic classification structure for identifying and filing records. They cover most subjects

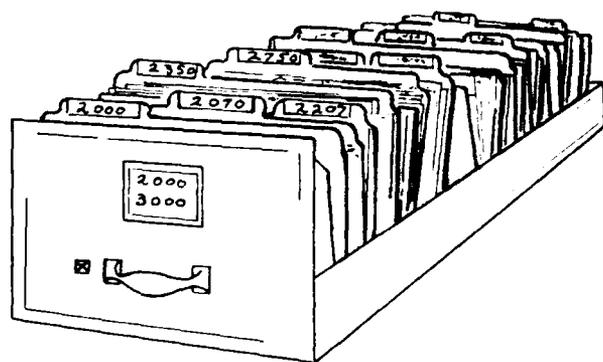


Figure 9-1.—Folders arranged using three different tab positions.

found in general correspondence files and reflect the major functions and operations of naval activities.

The SSIC is a four- or five-digit number that represents the subject of a document. SSICs are required on all Navy and Marine Corps letters, messages, directives, forms, and reports. They provide a tested method for filing documents and retrieving them quickly.

Numerical Subject Groups

The Navy's SSIC system consists of 13 major subject groups (figure 9-2). These major subject groups break down into primary, secondary, and sometimes tertiary subjects. Primary subjects are designated by the last three digits (the hundreds group) of the SSIC and secondary subjects by the last two digits. Tertiary subjects are designated by the final digit. For example:

6000 Medicine and Dentistry (*major subject group*)
6600 Dentistry (*primary subject*)
6630 Prosthetic Dentistry (*secondary subject*)
6631 Budget Requirements (*tertiary subject*)

Some of the smaller subject groups are not subdivided below the primary breakdown, while larger groups may have secondary and tertiary breakdowns.

Arrange your files based on the SSICs most often used by your activity. When you close 1 year's files, note the folders that contain the most documents, and label the new folders accordingly. Add new folders as the need arises.

FILING PROCEDURES

File material includes the following:

- The incoming document
- Copy of the outgoing correspondence
- Any essential supporting documents

Do not file unnecessary working papers, early drafts, extra copies, or information materials. Oversized material that cannot be folded to fit neatly is filed separately in a suitable cabinet. But note its location on the basic document or on a cross-reference sheet.

Loose filing of documents in folders is recommended, because it saves time and material. But some material, such as contract or personnel files, may require fasteners to hold pages in particular

1000 Series	- <u>MILITARY PERSONNEL</u> . Subjects relating solely to the administration of military personnel.
2000 Series	- <u>TELECOMMUNICATIONS</u> . Subjects relating to general communication matters, systems, and equipment.
3000 Series	- <u>OPERATIONS AND READINESS</u> . Subjects relating to operational plans, fleet operations, operational training, readiness, and intelligence, and research and development.
4000 Series	- <u>LOGISTICS</u> . Subjects relating to the logistical support of the Navy and Marine Corps, including procurement, supply control, property redistribution and disposal, and maintenance, construction, and production planning.
5000 Series	- <u>GENERAL ADMINISTRATION AND MANAGEMENT</u> . Subject relating to general personnel matters, security, external relations, law and legal matters, office services, and publication and printing matters.
6000 Series	- <u>MEDICINE AND DENTISTRY</u> . Subjects relating to physical fitness, general medicine, special or preventive medicine, dentistry, and medical equipment and supplies.
7000 Series	- <u>FINANCIAL MANAGEMENT</u> . Subjects such as budgeting, disbursing, accounting, auditing, and statistical reporting.
8000 Series	- <u>ORDNANCE MATERIAL</u> . Subjects relating to all types of ordnance material and weapons.
9000 Series	- <u>SHIPS DESIGN AND MATERIAL</u> . Subjects relating to such matters as the design, characteristics, and readiness of ships, and to ship's material and equipment.
10000 Series	- <u>GENERAL MATERIAL</u> . Subjects relating to general categories of materials not included above, such as photographic equipment and accessories, general machinery and tools, personnel material.
11000 Series	- <u>FACILITIES AND ACTIVITIES ASHORE</u> . Subjects relating to ashore structures and facilities, transportation facilities, utilities and services, and other similar subjects.
12000 Series	- <u>CIVILIAN PERSONNEL</u> . Subjects relating solely to the administration of civilian personnel.
13000 Series	- <u>AERONAUTICAL AND ASTRONAUTICAL MATERIAL</u> . Includes subjects relating to the types of aircraft and astronomical vehicles.

Figure 9-2.—Major subject groups of the Navy's SSIC system.

order and to prevent loss. Use prong fasteners rather than staples, clips, or rubber bands.

Keep track of all documents removed from the files. When a document or an entire folder is removed, put a charge-out slip (optional Form 23, 24, or 25) in its place. Update the charge-out slip if the document or folder changes hands.

Classifying

Classifying, as used here, is the process of determining the correct subject group under which documents should be filed, and any subordinate subjects that should be cross-referenced. Classifying is the most important filing operation, because it determines where papers are to be filed.

To subject classify a document, read it carefully, analyze it, and then select the file code that most closely corresponds to its subject. Consider the following factors:

- The most important, definite, or concrete subject mentioned.
- The purpose or general significance of the document.
- The manner in which similar documents are requested/filed.

Do not be misled by the SSIC placed on a letter by the originator. It may not be appropriate for your office files.

Coding

Coding is the process of writing the file number on papers to be filed. In the upper right corner, write the number under which the document will be filed. Show any appropriate cross-references. If the document is to be filed under the number assigned by the originator, simply circle the number.

Cross-Reference Filing

Although official documents usually are confined to one subject, they often may be properly classified under two or more file subjects. In such instances, a cross-referencing system permits you to easily locate filed documents.

Some correspondence will arrive with carbon copies. Use these copies as cross-references when needed. File one copy in each subject folder and indicate the location of the basic document. If no extra copies are available, use a Cross-Reference Sheet (OF-21). Complete the Cross-Reference Sheet by entering:

- The date and SSIC of the correspondence cross-reference
- The addressee(s), i.e., the "To" line of correspondence
- The originator
- The subject or a summary of the subject matter
- Where the original correspondence is filed
- Your initials
- Any pertinent remarks, such as the date certain action must be completed

If the OF-21 is not available to you, record cross-reference information on a plain sheet of paper and file it as discussed above.

A cross-reference sheet is also appropriate when enclosures are separated from the basic correspondence and when oversized material is filed in another cabinet.

RECORDS DISPOSAL

The contents of your files are of such significance that the Congress has passed laws governing their disposition and fixing penalties for unauthorized destruction. These laws apply to unclassified as well as classified material.

All tasks connected with files, including their disposition, must be taken seriously. Because you

may be responsible for maintaining activity files, you may also be involved in the proper disposal of those files. Never save files to avoid making decisions or because someone "might" need them. Conversely, do not dispose of them simply because no one is referring to them.

The *Navy and Marine Corps Records Disposition Manual*, SECNAVINST 5212.5 series, establishes records retention standards, provides disposition authority for naval records, and sets forth procedures for records retirement, destruction, and transfer. NAVMEDCOMINST 5210.1 series, *Forms, Reports, and Records Management Program*, defines records disposal responsibilities at the Naval Medical Command and its subordinate activities. The following discussions highlight the policies and procedures of both directives.

RECORDS DISPOSAL TERMINOLOGY

You must understand record disposal terms in order to understand records disposal policies and procedures. The following definitions should help.

RECORDS are documentary materials made or received by a U.S. Government agency under federal law or in connection with the transaction of public business. Records include books, papers, maps, and photographs, that are appropriate for preservation. They serve as evidence of the Federal Government's organization, functions, policies, decisions, operations, or other activities. Although information concerning such matters is contained in practically all records, immediate or future reference needs determine the relative importance of the records.

NONRECORD MATERIALS are items that have no documentary or evidential value in themselves and are needed for only a limited time. These include extra copies of documents retained for ready reference, follow-up, or convenience; personal notes or rough drafts; materials received from other government agencies or commercial firms (catalogs, trade journals); and library materials maintained exclusively for reference purposes.

PERMANENT RECORDS are long-term records that have enduring historical, research, legal, scientific, cultural, or other value. They comprise a small percentage of naval records and must be identified and marked for preservation.

TEMPORARY RECORDS are short-term records retained for a specific period of time or

until the occurrence of an action or event. They are normally disposed of within 5 years of their originating dates, most within 2 years. Temporary records must be identified, scheduled, and regularly destroyed.

FEDERAL RECORDS CENTER (FRC) is the records storage facility operated by the National Archives and Records Administration (NARA). The FRC houses noncurrent Federal Government records and is staffed to perform required reference, processing, and disposal services.

RECORDS RETIREMENT is the change in location within the activity, usually by removal to a local storage area.

RECORDS TRANSFER is the moving of records involving a change in custody; e.g., to the National Archives and Records Administration (NARA) or to a Federal Record Center (FRC).

FILE BREAK/CUT OFF refers to the termination of files at regular intervals so new files can be made. General correspondence files, as well as most other files, are cut off annually at the end of the calendar year. Budget and accounting records are cut off annually at the end of the fiscal year (30 September).

RECORDS DISPOSAL PROGRAM

The goals of the Navy's Records Disposal Program are to:

- Create records to document organization, functions, policies, procedures, decisions, and essential transactions of the DON
- Preserve records with long-term permanent worth
- Destroy temporary records that have outlived their usefulness
- Retire and transfer records no longer required in the conduct of daily business

You will find the records retention standards in Parts III and IV of the *Records Disposition Manual*. Use them as the basis of your activity's Record Disposal Program.

Figure 9-3 is an example of a portion of the Records Disposition Manual and shows the format of the retention standards.

<u>SSIC 6600-6699</u>	
<u>DENTISTRY RECORDS</u>	
THE RECORDS IN THIS (6600-6699) SERIES ARE RELATED TO GENERAL DENTISTRY RECORDS AND INCLUDE PROFESSIONAL SERVICE, TREATMENT, PROSTHETIC DENTISTRY, ORAL SURGERY, OPERATIVE DENTISTRY, PERIODONTIA, AND DENTAL SPECIALTIES RECORDS.	
<u>SSIC 6600</u>	
<u>GENERAL DENTISTRY RECORDS</u>	
1. DAILY DENTAL SERVICE RECORDS. Documentation by dental officers of procedures and services accomplished and used to complete dental service reports.	Destroy when 2 years old.
2. DENTAL SERVICE REPORTS	
a. <u>Quarterly Dental Statistical Reports at NAVMEDCOM</u>	Transfer to WNRC when 4 years old. Destroy when 15 years old.
b. <u>Quarterly Dental Statistical Reports at Dental Field Activities</u>	Destroy when 2 years old.
3. DENTAL EQUIPMENT AND FACILITIES REPORTS. Annual reports of dental spaces, equipment, prosthetic data, and utilities.	Apply par. 6000.1b.
4. DENTAL METALS. Issue records, statements, and inventories of precious and special dental metals.	Destroy when 2 years old.
5. PROSTHODONTIC WORK REQUESTS AND PRESCRIPTIONS. Records of dental prostheses fabricated and metals used. Records are maintained alphabetically by patient name.	Destroy when 2 years old.

Figure 9-3.—Sample records retention standards.

The standards identify records that should be classified as temporary or permanent and indicate how long you must retain them. They also identify records that must be transferred to a Federal Record Center, and they serve as authority for records disposal actions.

The retention period for a record is found under the same SSIC used to file it. This interlinking of file codes and retention standards simplifies the disposal program.

Establishing and Applying a Records Disposal Program

With the *Records Disposition Manual* as your guide, determine the exact disposition requirements for your activity's records, using the following procedure:

1. Inventory all records. Be sure to include records located within specific departments and those already cut off and moved to an in-house storage area. The inventory enables you to prepare a concise description of each record series; to determine record use, volume, and location; and to match each record series with its appropriate retention standard.
2. Analyze the inventory data and each record series to determine proper retention periods and disposition requirements.
3. Set cutoff and retirement periods for each records series.
4. To ensure timely records disposal, prepare disposal control guidance for each series and post on file cabinets, drawers, guides, or folders, to include: SSIC and title; specific cutoff dates and, if applicable, transfer dates; retention period or disposal date; and number of the paragraph in Parts III or IV of the *Records Disposition Manual* containing authority for the retention being applied.
5. Take action immediately to apply disposal instruction to eligible records:
 - Destroy records with expired retention periods.
 - Retire inactive records to local storage area for destruction.

- Transfer to the Federal Records Center any authorized long-term records not eligible for destruction in the near future.

6. Appraise records not covered.

7. Schedule disposal actions, preferably annually at the end of the calendar year.

An activity must also keep local guidance current, make annual reviews of disposal procedures, and keep statistics on volumes of records held.

You will most likely be concerned with destruction and transfer. Individual commands normally set up a destruction schedule. Most unclassified records are destroyed locally at the end of their retention periods. Classified material must be destroyed by a method authorized in the Security Manual.

One note of caution: even though a disposition date may have passed, do not dispose of records on which action is pending.

NAVAL CORRESPONDENCE

As an advanced dental assistant, you may be required to compose correspondence from brief notes or from oral instructions. Your written product reflects upon your capabilities and attention to detail. Likewise, the quality of correspondence addressed to other commands reflects upon your command.

To meet this requirement, you must know the basic naval correspondence policies and procedures. The following discussions provide the general requirements. For details, consult the *Department of the Navy Correspondence Manual*, SECNAVINST 5216.5 series.

NAVAL WRITING STANDARDS

Though correspondence formats are important, writing quality is perhaps more important because effective communication is your goal. For that reason, this section begins with information on how to make your writing organized, natural, compact, and active.

Organized Writing

Before you begin, have your objective clearly in mind. Use the newspaper pattern: open with the most important information taper off to the least important.

Start with your main point—requests *before* justifications, conclusions before discussions, etc. To soften bad news or to introduce a controversial proposal, you may delay your main point. But don't delay routinely. If you have a number of key points, don't try to put them all in the first paragraph. Start with a general statement of purpose, and then discuss each point before starting another.

Down-play references whenever possible. Reading slows with every glance from the text to the reference block. Use only those references that bear directly on your subject. And don't waste your opening (the strongest place in a letter) to make mention of references.

Use paragraphs and topic sentences, and use more parallelism. Make sentence elements that are similar in thought similar in form. Parallelism saves words, clarifies ideas, and provides balance.

Natural Writing

Make your writing as formal or informal as the situation requires, but do so with language you might use in speaking. This makes it more readable.

Use personal pronouns. Speak of your activity, command, or office as *we*, *us*, *our*. Use *you* to refer to the reader. Use *I*, *me*, *my* only to show special concern or warmth.

Rely on everyday words. Some big words are necessary, but don't use them when little ones will do; e.g., use *help for assistance*, *pay for remuneration*.

Keep sentences short, but for variety mix long and short sentences. Though short sentences won't guarantee clarity, they are usually less confusing.

Tone, a writer's attitude toward a subject or readers, is of little concern in routine letters. But it can cause problems in a delicate matter. The more sensitive the reader or issue, the more careful you must be to promote good will. Give some explanation for most *no* answers. Be positive; e.g., instead of "opportunity is limited," say "competition is keen."

Compact Writing

Use no more words than necessary. Wordiness risks blurring of important ideas. Tighten paragraphs to sentences, sentences to clauses, clauses to phrases, phrases to words—or strike ideas entirely. Be easy on your readers and hard on yourself.

Avoid "it is" and "there is." They stretch sentences, delay meaning, hide responsibility, and encourage passive verbs.

Prune wordy expressions; e.g. *in order to* (to), *is responsible for* (handles). They clutter writing by getting in the way of words that carry meaning.

Free smothered verbs. A verb is the most important word in a sentence. It is the *action* word, the only word that can *do* something. Don't say "make a choice" when you can use the specific verb "choose."

Splice doublings. As a writer, you may see some differences between *advise* and *assist* or *thanks* and *gratitude*. But *your* readers won't. Repeating a general idea will not make it any more precise.

Shun the use of words ending in *-ion* and *-ment*. Whenever context permits, use the verb forms to make your sentences shorter and livelier.

Active Writing

Learn to spot passive verbs and make them active. Passive verbs make writing wordy, roundabout, and even confusing. Use the who-does-what order for most of your sentences. Example:

Active: The skipper inspected the ship.

Passive: The ship was inspected by the skipper.

TYPES OF CORRESPONDENCE

Selecting the proper means of communicating information is of special importance for command operations. Consider time, subject matter, and the addressee. The following paragraphs outline policies and procedures set forth in the *Correspondence Manual*, SECNAVINST 5216.5 series.

Standard Letter

Use the standard letter for official correspondence with Department of Defense (DOD) activities. You can also use it with organizations outside the DOD if they have adopted the format, e.g., the Coast Guard and some contractors.



1
2
3
4

*DEPARTMENT OF THE NAVY
*Name of Activity
*Address

1
2

SSIC
Code/Serial
*Date

1
2 From: Title of activity head, name of activity, location when needed
To: Title of activity head, name of activity, location when needed (Code)
Via: (1) Title of activity head, name of activity, location when needed (not numbered if only one)
(2) Pattern of (1) repeated for next endorser

1
2 Subj: NORMAL WORD ORDER, ALL LETTERS CAPITALIZED

1
2 Ref: (a) Earlier communication that bears directly on subject at hand

1
2 Encl: (1) Material enclosed with letter identified in same way as reference, single enclosure numbered
(2) Notation added for material sent separately (sep cover)

1
2 1. This example shows all the elements that might appear on the original of a one page standard letter. .
2. If you omit the date when you type the letter, start the from block on the fourth line below the code/serial to allow for an oversized date stamp.
3. Refer to the Correspondence Manual for other examples that show the spacing to follow for correspondence that variously omits via, reference, and enclosure blocks.

1
2
3
4

*NAME OF SIGNER
*By direction

1
2

Copy to:
Short title of information addressee (see SNDL)
Short title of second information addressee

ITALICS: OPTIONAL ITEMS
ASTERISKS: ITEMS YOU MAY STAMP
UNDERLINED NUMBERS: TYPEWRITER LINES

Figure 9-4.—Standard letter.

Prepare the first page of a standard letter on letterhead bond paper (figure 9-4). Try to keep letters short, using enclosures for unavoidable lengthy explanations. If you must use a second page, repeat only the subject.

To ensure legible reproduction, use black or blue-black ink to type, stamp, and sign correspondence. For reading ease, prefer larger, pica type over smaller, elite type. Save script or italics for occasional emphasis, never to type an entire letter.

Joint Letter

Use a joint letter to establish an agreement between two or more commands or for other matters

of mutual concern. Figure 9-5 illustrates a joint letter and provides basic preparation procedures.

Multiple-Address Letter

Normally, use a multiple-address letter when you have more than one action addressee. Except in its handling of addressees, the multiple-address letter is the same as the standard letter.

There are three ways to list addressees on a multiple-address letter. You may use the to block by itself as shown in figure 9-6, or use the distribution block by itself, or use both blocks.



DEPARTMENT OF THE NAVY
 NAVAL AIR STATION
 CECIL FIELD, FLORIDA 32215

5216
 Ser 11/352
 3 Jun 87

From: Commanding Officer, Naval Air Station, Cecil Field
 To: Commander in Chief, U.S. Atlantic Fleet
 Via: (1) Commander, Sea Based ASW Wings, Atlantic
 (2) Commander, Naval Air Force, U.S. Atlantic Fleet

Subj: HOW TO PREPARE ENDORSEMENTS

Encl: (1) Orientation Schedule for Newcomers

1. Same-page endorsements may be added to a basic letter, like this one, or to a previous endorsement. This sentence cites enclosure (1).

J. M. Shuttleworth
 J. M. SHUTTLEWORTH

1
 2
 1
 2

Ser 019/870
 17 Jun 87

1
 2
 1
 2

FIRST ENDORSEMENT

From: Commander, Sea Based ASW Wings, Atlantic
 To: Commander in Chief, U.S. Atlantic Fleet
 Via: Commander, Naval Air Force, U.S. Atlantic Fleet

1
 2

1. Start an endorsement on the same page as the latest communication if the answer to all three questions is yes:
 - a. Is the latest communication less than one page?
 - b. Will all of the endorsement fit on that page?
 - c. Is the endorsement sure to be signed without revisions?
2. A same-page endorsement may omit the SSIC, and basic letter's identification as long as the entire page will be photo-copied. However, all three elements are required if you make carbon copies. These elements are also required on all new-page endorsements.

1
 2
 3
 4
 1
 2

W. J. WALLISCH

Copy to:
 NAS Cecil Field (Code 11)

Figure 9-7.—Same-page endorsement.

Endorsement

Use an endorsement to respond to a letter when you are a via addressee. Use either a same-page endorsement (figure 9-7) or a new-page endorsement (figure 9-8). Always keep an endorsement with the basic letter.

Many endorsements simply forward letters to the next addressee. There is no need for substantive comment. But others may require comments on the basic letter or earlier endorsements. An endorsement may alter the order of remaining via addressees or add others. And it may return the

basic letter with a final reply or a request for more information.

Show only the references and enclosures that you add. Assign reference letters and enclosure numbers by continuing the earlier sequence.

Speedletter

Use speedletters for urgent UNCLASSIFIED matters that don't require electrical transmission. The speedletter calls attention to the need for priority handling. Use it when speed of delivery is important, not just because it is easy.



DEPARTMENT OF THE NAVY
COMMANDER NAVAL AIR FORCE
UNITED STATES ATLANTIC FLEET
NORFOLK, VIRGINIA 23511

1
2

5216
Ser N72/4201
24 Jun 87

1
2 SECOND ENDORSEMENT on NAS Cecil Field ltr 5216 Ser 11/352 of
3 Jun 87

1
2 From: Commander, Naval Air Force, U.S. Atlantic Fleet
To: Commander in Chief, Atlantic Fleet

1
2 Subj: HOW TO PREPARE ENDORSEMENTS

1
2 Encl: (2) SECNAVINST 5216.5C

1
2 1. Start an endorsement on a new page if the answer to one or more of
these questions is no:

- a. Is the latest communication less than one page?
- b. Will all of the endorsement fit on that page?
- c. Is the endorsement sure to be signed without revision?

2. Number every page; continue the sequence of numbers from the previous communication, as explained in enclosure (2).

3. Like a same-page endorsement prepared with carbon copies, every new-page endorsement must--

- a. Repeat the basic letter's SSIC.
- b. Identify the basic letter in the endorsement-number block.
- c. Use the basic letter's subject as its own.

1
2
3
4

H. H. MILLER
By direction

1
2 Copy to:
NAS Cecil Field (Code 11)
*COMSEABASEDASWINGLANT (Code 019)

*Prior endorser appears because second endorsement is significant.

Figure 9-8.—New-page endorsement.

Prepare a speedletter on the special form, Naval Speedletter, OPNAV 5216/145 (figure 9-9). The form is a carbon set of six identical pages: the top three for outgoing copies, the bottom three for internal use. Use plain paper for continuation pages. Follow standard-letter practice, do not use via addressees. Show those who would appear as via addressees as copy-to addressees instead.

Memorandum

A memorandum is used to informally correspond within an activity or between several activities. Subordinates may use it to correspond directly with each other on routine business.

Choose the format that suits the subject, occasion, and audience. Your choices, starting with the most informal, are:

1. The printed memorandum form (figure 9-10)
2. The plain-paper memorandum (figure 9-11)
3. The letterhead memorandum (figure 9-12)
4. The memorandum-for (figure 9-13)

If the subject is insignificant, no file copy is required.

SECNAINST 5216.5C		
NAVAL SPEEDLETTER		
1 IN REPLY REFER TO 5216 Ser N31/397	2 PHONE NUMBER (Original) AV 922-3511	3 DATE 11 Feb 87
4 TO		INSTRUCTIONS
<ul style="list-style-type: none"> • Commander, Atlantic Division (Code 09A31) Naval Facilities Engineering Com. Norfolk, VA 23511 		<ul style="list-style-type: none"> • Use for urgent unclassified matters only • Message abbreviations may be used • Keep addresses to four lines and within the date include attention codes whenever known • Give priority to routing and avoid time-consuming circuits • Use a number 10 window envelope for mailing
5 REFERENCES AND ENCLOSURES, IF ANY TEXT AND SIGNATURE (Field)		
Subj: HOW TO PREPARE A SPEEDLETTER Ref: (a) SECNAINST 5216.5C 1. The subject, reference, and enclosure blocks follow the pattern of the standard letter as required by reference (a). 2. Margins may be less than one inch. 3. Short speedletters may be penned. 4. If a response is expected, you may include a white copy with the blue original. The addressee may reply on the white copy and keep the blue one.		
C. L. PALMER By direction (Field)		
6 COPY TO		
CHESNAVFACENGCOM		
7 FROM		
<ul style="list-style-type: none"> • Chief of Naval Education and Training Naval Air Station Pensacola, FL 32508 		
		← When replying on this form show this subject in a number 10 window envelope

Figure 9-9.—Naval speedletter.

OPNAV 5216/144A (Rev. 8-81)
S/N 0107-LF-062 2320

DEPARTMENT OF THE NAVY

Memorandum

DATE: 16 Mar 87

FROM: OP-098R (77256)

TO: OP-098

SUBJ: PRINTED MEMORANDUM FORM

Ref: (a) SECNAVINST 5216.5C

Encl: (1) Personnel Roster

1. This printed form is the most informal memorandum. Use it among individuals and offices of the same activity.
2. The memorandum form comes in three sizes.
 - a. OPNAV 5216/144A (8-1/2 by 11 inches).
 - b. OPNAV 5216/144B (8-1/2 by 5-1/2 inches).
 - c. OPNAV 5216.144C (5-1/2 by 8-1/2 inches).
3. Except for the date, no sender's symbols are necessary.
4. Use names, titles, or codes in the from and to blocks.
5. Allow a 1-inch left margin.
6. Type reference and enclosure headings under the printed headings. Note the headings for reference (a) and enclosure (1).
7. The writer signs his or her name without an authority line.
8. Very informal memoranda may be penned.
9. No file copy is necessary when the matter is insignificant or short lived.

M. D. Hartung

Figure 9-10.—Printed memorandum form.

1
2
3
4
5
6

10 Sep 87

1
2
1
2

MEMORANDUM

From: Head, Organization and Directives Branch (Code 211)
To: Head, Technical Library Branch (Code 111)
Head, Mail and Files Branch (Code 112)
Via: Head, Office Services Division (Code 110)

1
2

Subj: PLAIN-PAPER MEMORANDUM

1. The plain-paper memorandum may be used within your activity.
2. It is no more formal than the memorandum form, but it is more flexible when there are multiple addressees, via addressees, or both.
3. Prepare a plain-paper memorandum on white bond.

1
2
3
4

M. ROY

Figure 9-11.—Plain-paper memorandum.



DEPARTMENT OF THE NAVY
 NAVAL AIR REWORK FACILITY
 ALAMEDA, CALIFORNIA 94501

1
 2

5216
 memo 28/87
 18 May 87

1
 2
 1
 2
 MEMORANDUM

From: Head, Management Services Department
 To: Operation Officer, Navy Regional Data Automation Center,
 San Francisco

1
 2
 Subj: LETTERHEAD MEMORANDUM

1. When direct liaison is authorized and the matter is routine, a memorandum (on letterhead paper) may be sent outside your activity.
2. When used within an activity, the letterhead memorandum provides more formality than the printed memorandum form.

1
 2
 3
 4

C. R. DOUGLAS

Figure 9-12.—Letterhead memorandum.



DEPARTMENT OF THE NAVY
 OFFICE OF THE CHIEF OF NAVAL OPERATIONS
 WASHINGTON, DC 20350

5216
 Ser 943D/345507
 11 Mar 87

1
 2
 MEMORANDUM FOR THE DEPUTY CHIEF OF NAVAL OPERATION (SURFACE WARFARE)
 (OP-03)
 DIRECTOR, NAVAL WARFARE (DP-095)

1
 2
 Subj: THE MEMORANDUM-FOR

1. The memorandum-for is the most formal memorandum. It may be used in writing to senior officials who traditionally have used it. Among them are the Secretary of Defense and the Secretary of the Navy.
2. Because the memorandum-for lacks a from block, show the signer's title below the typed name.
3. Multiple addressees are listed as shown above.

1
 2
 3
 4

H. A. JONES
 Director, Navy Space
 Systems Division

Figure 9-13.—Memorandum-for.



DEPARTMENT OF THE NAVY
 USS CUSHING (DD 985)
 FPO SAN FRANCISCO, CA 96662

1
 2
 5216
 Ser DD 985/28
 January 5, 1987

1
 2
 Coover Precision, Inc.
 Attn: E. Jones
 6923 W. Hobson Blvd.
 New York, NY 11378

1
 2
 Gentlemen:

1
 2
 When writing to a company in general but directing your letter to a particular person or office, use an attention line between the company's name and its address. Type Attn: and then a name or title.

Make the salutation agree with the first line of the address. If the first line is a company name, the salutation is Gentlemen even if the attention line directs the letter to an individual. Note the inside address and salutation in this letter.

1
 2
 1
 2
 3
 4

Sincerely,

G. E. JENKINS
 Commander, U.S. Navy
 Executive Officer
 By direction of
 the Commanding Officer

1
 2
 Encl:
 (1) Correspondence Manual (sep cover)

Figure 9-14.—Business letter.

Business Letter

Use the business letter (figure 9-14) to correspond with agencies or individuals outside the Department of the Navy. It may also be used for official correspondence between individuals within the Department of the Navy when the occasion calls for a personal approach.

Because the business letter has no from block, every copy that goes outside your activity must be on letterhead. Use sender symbols and page numbers on succeeding pages. Refer in the text to any previous communications. Do not use references. Use Sincerely for the complimentary close.

THE NAVAL MESSAGE

You will have to be able to read and interpret naval messages; you may be required to draft and prepare them. Therefore, you must be familiar

with message format and message drafting procedures.

A message is an official communication transmitted by rapid means. Use it when speed is of primary importance. Do not use a message when a letter or speed letter will get the information to its destination in time for proper action.

The *Naval Telecommunication Procedures, Telecommunication Users Manual, NTP 3*, contains detailed procedures for drafting naval messages. NTP 3 procedures are mandatory; follow them carefully. Local telecommunications centers often provide instructions that amplify NTP 3.

Types of Messages

There are different message types, based on how they are addressed: single-address, multiple-address, book, and general. You will most likely prepare either single-address (one addressee) or

multiple-address (two or more action or information addressees) messages.

Book messages are designed for two or more addressees but are of such nature (e.g., commercial bids) that the originator considers that no addressee need or should be informed of any other addressee.

General messages are used to pass information to all commands or to types of commands or activities. You are probably familiar with general messages by their titles, e.g., ALCOM (All Commands), ALCOMPAC (All Commands Pacific), NAVOP (Naval Operations). Although you may not prepare general messages, you will certainly receive and interpret them.

Message Responsibilities

Your specific responsibilities concerning messages depend upon your involvement with each one. Normally, you are only the drafter or addressee of the message, but you should be aware of all message responsibilities.

The message originator is the authority (command or activity) in whose name the message is sent. The originator is responsible for the message release and drafter functions.

The message releaser is an individual authorized to release a message for transmission in the name of the originator. The releaser validates message content and affirms compliance with message drafting instructions. Your commanding officer is usually the releaser, but authority may be delegated.

The drafter is the person who composes the message. The drafter must have detailed knowledge of NTP 3 procedures. As a drafter, you are responsible for:

- Properly addressing the message
- Composing the message clearly and concisely
- Properly applying appropriate security classification, special handling, and declassification markings
- Selecting an appropriate message procedure
- Ensuring that the message is correctly formatted and error free

The addressee's responsibilities depend upon the type of addressee, i.e., action or information

addressee. If your command is an action addressee, the message may require a response or an immediate action. If your command is an information addressee, the message normally requires no action on your part, but must be reviewed carefully.

Message Precedence

The precedence system enables the message drafter to indicate a desired writer-to-reader delivery time. For an addressee, precedence indicates the importance of the message, but has no direct effect on response or action time. Precedence is based on urgency. If you are preparing a message, determine its precedence on the basis of delivery time rather than the importance of the subject matter.

There are five precedence categories: routine, priority, immediate, flash, and emergency command. You will deal mostly with the routine and priority categories; the others relate to situations that gravely affect the national forces and populace.

Routine is the precedence assigned to messages that are not of sufficient urgency to require a higher precedence. Handling and delivery time is normally within 6 hours. Use this precedence for normal peacetime operations, programs and projects, and administrative and personnel matters. Use it for supply and equipment requisitions except when time factors dictate use of a higher precedence.

Priority is reserved for messages that furnish information essential for conducting operations in progress. It is the highest precedence and is normally authorized for administrative, logistical, and personnel matters of a time-sensitive nature. Handling and delivery time is normally within 3 hours.

Message Format

Prepare a naval message on the Joint Message, DD Form 173/2. Because messages are machine-read, format requirements and preparation procedures are very specific. You must precisely follow the instructions provided in NTP 3. The following paragraphs, together with the sample

message shown in figure 9-15, provide only basic information. Consult NTP 3 for details.

Naval messages are identified by a date-time-group (DTG). The DTG is normally assigned by the Telecommunications Center (TCC). You may, however, assign a DTG to the message you prepare if deemed more expedient. The DTG consists of six digits, a time zone suffix, and the abbreviated month and year of origin (e.g., 021930Z JAN 87). The first pair of digits (02) denotes the day of the month, and the last four (1930) indicate

the time the message was prepared. Express all DTGs in Greenwich Mean Time (Z) unless otherwise directed.

The address component of a message contains the plain language address (PLA) of the message originator, the action, and any information addressees. The PLA includes an activity's short title and geographic location. You will find PLAs in the *U.S. Navy Plain Language Address Directory (PLAD)*, NTP 3 SUPPL-1.

JOINT MESSAGEFORM						SECURITY CLASSIFICATION UNCLASSIFIED				
PAGE	DTG/RELEASE TIME			PRECEDENCE		CLASS	SPECAT	LMI	C/L	ORIG MSG IDENT
	DATE TIME	MONTH	YR	RLY	INTL					
1 of 1	172140Z	OCT	83	RR	RR	UUUU				2902140Z
MESSAGE HANDLING INSTRUCTIONS										
<p>FROM CNO WASHINGTON DC</p> <p>TO USS LEXINGTON</p> <p>INFO: COMNAVAIRLANT NORFOLK VA</p> <p>UNCLASS//N05216//</p> <p>SUBJ: MESSAGE FORMAT</p> <p>A. SECNAVINST 5216.18</p> <p>1. (TEXT)</p> <p>2. (TEXT)</p> <p>3. (TEXT)</p>										
DISTR										
ACTION: CODE 11										
DD...01...03...04										
DRAFTER (TYPED NAME, TITLE, OFFICE SYMBOL, PHONE)						SPECIAL INSTRUCTIONS				
R. E. JONES, LT, OP-43, 17034, 1 FEB										
SIGNATURE						SECURITY CLASSIFICATION				
J. W. RAIN TREE, CAPT, OP-4, 17023						UNCLASSIFIED				
DATE TIME GROUP										

Figure 9-15.—Format for Naval Message.

As you can see in figure 9-15, message text components consist of the classification, subject, reference lines, and message text. On the classification line, indicate the message classification and the SSIC. For the subject line, type the SUBJ of the letter. Do not type REF for the reference line; simply letter references consecutively, one beneath the other. The message text contains the information you desire to communicate. Brevity is essential, but not at the cost of accuracy. Abbreviations are authorized, but use only those whose meanings are self-evident or recognizable from common use.

Type a message using an optical character recognition (OCR) font and a carbon ribbon. Use only uppercase letters, arabic numerals, punctuation, and the symbols authorized in NTP 3. Ensure that alignment, spacing, and margins conform to requirements so the OCR scanner can read all of the characters.

NAVY MAILED MESSAGE (NAVGRAM)

A Navy mailed message (NAVGRAM) is a message processed through the mail vice a communications center. Designed to call attention to the need for priority handling, the NAVGRAM will eventually replace the naval speedletter. Use it to correspond with only Department of the Navy activities on urgent SECRET and below matters.

Prepare a NAVGRAM on the Joint Message form just as you would a standard naval message. Assign a letter serial number in the DTG box in the lower right-hand corner of the message form. In light red ink, stamp "NAVGRAM" in the center of the page for easy identification.

CORRESPONDENCE MANAGEMENT

Preparing and handling correspondence is time consuming and expensive. To reduce costs, follow the correspondence management practices listed below as closely as possible.

1. Write only when necessary; include your phone number when your correspondence might prompt a reply or inquiry.
2. Use more window envelopes for *unclassified* correspondence. This eliminates the cost of addressing envelopes and the risk of putting letters

in the wrong envelopes. Refer to the Correspondence Manual for format.

3. Use more form and guide letters. Watch your outgoing correspondence for recurring topics. Use form letters for routine matters that require no personal touch. Guide letters consist of a series of paragraphs from which the writer chooses the best one for a particular situation. The speed and flexibility of word processors and computers make guide letters increasingly attractive.
4. Coordinate correspondence functions efficiently. Before you write, obtain agreement of interested parties by phone or in person. If revisions are likely, coordinate during the drafting stage. Show the order of routing on the file copy or a special coordination form. If many offices must coordinate and time is short, you can fan out copies to all coordinators simultaneously. Then summarize their responses on a briefing sheet that accompanies the letter when it goes for signature.

The originator is responsible for working to resolve major differences, for any retyping that may be needed, and for providing copies of the signed correspondence to coordinators who request them.

5. Normally, submit correspondence for signature in final form. Early consideration of a signer's preference reduces the frequency of changes.
6. Make minor changes in ink. Rarely retype correspondence already in final form merely to correct typographical errors, word omissions, or other minor mistakes. Make these corrections legibly in ink, correcting all copies at the same time. Two ink changes are permitted on a page. Retype to correct minor errors in only those few cases when the importance of the subject or the addressee justifies the expense.
7. See that correspondence is signed and mailed promptly. It should be signed throughout the day rather than just at the end of the day, so it doesn't linger overnight.
8. Give prompt attention to incoming correspondence that requires action or answers. Normally, answer correspondence within 15 work days or in the time set by the incoming correspondence. Congressional correspondence must be answered

within 5 work days of receipt. When you foresee an excessive delay, give an anticipated date of response. Use the printed postcard, Correspondence Acknowledgment, OPNAV 5216/125.

9. Limit costly photo copies of correspondence. Pinpoint the required quantity precisely and make two sided copies whenever possible. Limit information copies to only those copy-to addressees with a genuine need to know. Make the most of the "read, initial, and date" approach to information copies within your activity. Circulate a single copy among those who are to read the document.
10. Avoid unnecessary file copies. Centralize files whenever possible to eliminate redundant ones.
11. Reuse paper. Use salvaged paper (e.g., obsolete forms) for written or typed drafts, computations, and rough notes.

SUMMARY

Nearly everything accomplished in daily military life is guided by some type of publication or correspondence. Knowing where to find information and being able to understand it are major factors in the successful performance of your administrative duties.

The Navy's filing system ensures that uniform filing procedures are followed by all naval activities. SSICs form the basis of this system and also provide a means of identifying letters, messages, directives, forms, and reports. Arrange your files according to the SSICs most often used or seen by your activity. Include only incoming and outgoing documents, and any essential supporting documents.

Because you may be responsible for maintaining your activity's files, you may also be directly involved in their destruction or preservation. The Records Disposition Manual establishes records retention standards, provides disposition authority for naval records, and sets forth procedures for records retirement, destruction, and transfer. Base all records disposal decisions on the contents of that manual. Post your records disposal guidance to ensure that such decisions are carried out.

Preparing correspondence and following good correspondence management practice are tasks you may perform as an advanced dental assistant. Select the type of correspondence that meets the needs of the situation, and ensure that it meets both format and writing quality requirements. Remember, the quality of correspondence addressed to other commands reflects upon your command.

REFERENCE LIST

- NAVMEDCOMINST 5210.1 series, *Forms, Reports, and Records Management Program*, November 1984
- SECNAVINST 5210.11 series, *Department of the Navy Standard Subject Identification Codes*, August 1982
- SECNAVINST 5212.5 series, *Navy and Marine Corps Records Disposition Manual*, July 1985
- SECNAVINST 5216.5 series, *Department of the Navy Correspondence Manual*, August 1983
- NTP 3, *Naval Telecommunications Procedures, Telecommunications Users Manual*

CHAPTER 10

DENTAL REPORTS AND REPORTS CONTROL

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify reporting responsibilities and preparation requirements for the Dental Equipment and Facilities Report.
2. Identify the elements and preparation requirements of the Dental Information Retrieval System Treatment Report.
3. Identify the elements and preparation requirements of the Statement and Inventory of Precious and Special Dental Metals.
4. Identify reports control requirements and procedures.

Every dental facility is required to prepare and submit certain special and periodic reports. These reports inform others of specific situations or events, provide required information, indicate completion of a specific task or assignment, and/or record data for future reference. Failure to submit reports reflects negatively upon your activity. Inaccurate report submissions may affect your facility's financial, personnel, or mission status.

Your facility's specific reporting requirements are outlined in chapter 23 of the Manual of the Medical Department. Other requirements are found in directives issued by higher authority. This chapter covers only reports required of most dental facilities. It does not cover all reporting requirements, nor those unique to a particular facility. Reports control procedures are included to help you meet your activity's reporting requirements.

DENTAL EQUIPMENT AND FACILITIES REPORT

The Dental Equipment and Facilities Report, NAVMED 6750/4, is an annual report of dental spaces, equipment, prosthetic data, and utilities. It provides:

- Data for developing dental logistic plans and budget requests.
- Information for initiating facility design, construction, or alteration proposals.

- A means of continuous review of existing dental facilities and the material within them.

The NAVMED 6750/4 is assigned report symbol **MED 6750-1** for identification and control purposes. Cite the report symbol on all correspondence referring to this report.

REPORTING RESPONSIBILITY OF NAVMED 6750/4

All activities having dental equipment (except field type equipment) must submit a NAVMED 6750/4 as of 1 January each year. An up-to-date NAVMED 6750/4 is required upon completion of major facility alterations or new construction. Submit a report for a newly constructed facility when it becomes operational.

Naval dental clinics (NDCs) must submit a separate NAVMED 6750/4 for each branch dental clinic, annex, and separate building having dental equipment. A consolidated report for the entire region is also submitted. If your activity has only field type equipment, you are not required to submit this report.

If your activity furnishes dental operating facilities to a dental company, or similar unit, make an entry to that effect in the Remarks and Recommendations section of the report. Prepare a separate NAVMED 6750/4 for each mobile dental trailer, van, or bus for which your facility has operational control.

**PREPARATION AND SUBMISSION OF
NAVMED 6750/4**

As an advanced dental assistant, you will likely be actively involved in preparing the NAVMED 6750/4. Here we highlight some important aspects of its preparation. A sample report is provided in figures 10-1A through 10-1D for your reference

during this discussion. You will complete all applicable items on the report, as directed in NAVMEDCOMINST 6750.1 series.

Part I, Dental Facility Spaces, requires data on all rooms within your facility. Indicate the number of each type, the number in use, and whether or not they are adequate. Explain any entries indicating inadequate spaces, and enter any

DENTAL EQUIPMENT AND FACILITIES REPORT							Report Symbol MED 6750-1
DATE OF REPORT	1 January 87	UIC	00043	SUB-UNIT	01		
FACILITY	Naval Dental Clinic, Bldg. #038, Naval Sail, CA 92000						
PART I - DENTAL FACILITY SPACES							
SPACE	NUMBER ON HAND	NUMBER IN USE	APPROXIMATE SIZE W X L	ADEQUATE		REMARKS	
	A	B	C	YES	NO		
1. DENTAL TREATMENT ROOM	14	13	12' x 10'	X		1 Not equipped Too Small	
	2	2	8' x 11'		X		
2. EXAMINING ROOM	2	2	11' x 10'	X			
3. ORAL HYGIENE INSTRUCTION ROOM	1	1	10' x 10'	X			
4. CENTRAL STERILIZATION ROOM	1	1	12' x 16'	X			
5. X-RAY EXPOSURE ROOM	1	1	8' x 10'	X			
	1	1	10' x 10'	X			
6. DARKROOM	1	1	6' x 8'	X			
7. PROSTHETIC LAB	1	1	8' x 10'		X	Too Small	
8. STOREROOM/SUPPLY ROOM	1	1	18' x 18'	X			
9. CONFERENCE ROOM	1	1	14' x 18'	X			
10. ADMINISTRATIVE OFFICE	1	1	8' x 8'		X	Too Small	
11. DENTAL CONSULTATION ROOM	2	2	10' x 10'	X			
12. DENTAL OFFICERS OFFICE	1	1	12' x 12'	X			
13. DENTAL REPAIR SHOP	1	1	16' x 20'	X			
14. PATIENT WAITING ROOM	1	1	16' x 16'	X			
15. RECORDS CONTROL OFFICE	1	1	10' x 10'	X			

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Figure 10-1A.—Dental Equipment and Facilities Report, NAVMED 6750/4.

16. OFFICER LOCKER (MALE)	1	1	10' x 10'	X		
17. OFFICER LOCKER (FEMALE)	1	1	9' x 10'	X		
18. ENLISTED LOCKER ROOM (MALE)	1	1	10' x 10'		X	Too Small
19. ENLISTED LOCKER ROOM (FEMALE)	1	1	8' x 10'		X	Too Small
20. TOILET FACILITIES (MALE)	3	3	6' x 8'	X		
21. TOILET FACILITIES (FEMALE)	2	2	8' x 8'	X		
22. OTHER MAJOR ROOMS Equipment Room	1	1	18' x 20'	X		
23. CLINIC UNIT Naval Dental Clinic, Bldg. #038	1	1	140' x 150'	X		Prosthetic Lab Included
PART II - DENTAL EQUIPMENT						
SECTION A - DENTAL OPERATING EQUIPMENT						
ITEM	MANUFACTURER AND MODEL A		NUMBER ON HAND	NUMBER IN USE	CONDITION CODE	
			B	C	D	
1. DENTAL OPERATING UNIT	Adec 2006		14	13	A4(13) E7(1)	
	Adec 2008		2	2	A4(2)	
	Adec 2000		2	2	A4(2)	
2. DENTAL OPERATING CHAIR	Den-tal-ez		18	17	A4(17)E7(1)	
	Royal 14-3T (X-ray)		1	1	A4(1)	
3. DENTAL OPERATING LIGHT	Pelton Crane LF+		10	9	A4(9)E7(1)	
	Pelton Crane LFII		8	8	A4(8)	
4. CENTRAL VACUUM SYSTEM	U.S. General Turbine 20T, 20 HP		2	2	A4(2)	
	Dentsply MVS		1	1	A4	
5. AIR COMPRESSOR DEHYDRATOR	Air Techniques A12-T		2	2	A4(2)	
	Worthington Air Dryer 430		2	2	A4(2)	
6. STERILIZER (LARGE)	Castle Thermatic 60 (Steam)		2	2	A4(2)	
7. STERILIZER (PORTABLE)	Pelton Crane OCM		10	6	A4(6)E8(4)	

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Figure 10-1B.—Dental Equipment and Facilities Report, NAVMED 6750/4—Continued.

other significant information in column E (Remarks). If space in column E is too limited, continue in Part V.

Part II, Dental Equipment, has three sections: dental operating, prosthetic, and x-ray equipment. Enter the total number of each item on hand, including those in storage or installed but not in use.

List major operating and prosthetic equipment items carried as Class 3 plant property.

Part III, Prosthetic Facility Data, requires information on your activity's prosthetic capabilities. If prosthetic facilities are attached, enter the highest number of cases fabricated in 1 month when fully staffed. Consider only cases

8. LIFE SUPPORT EQUIPMENT	Physio-Control Lifepak 6	1	1	A4	
9. OTHER MAJOR EQUIPMENT	None				
SECTION B - PROSTHETIC LAB EQUIPMENT					
ITEM	MANUFACTURER AND MODEL A	NUMBER ON HAND B	NUMBER IN USE C	CONDITION CODE D	
1. INDUCTION CASTING MACHINE	Ticonium Ticomatic	1	1	A6	
2. VACUUM PORCELAIN FURNACE	Unitek 500	1	1	A6	
3. DUPLICATOR	Ticonium Ready Duplicator (Manual) 1453 G1	1	1	A6	
4. BURNOUT OVEN	Jelenko Accu-Therm 250	2	2	A6(2)	
5. HIGHSPEED POLISHER/GRINDER	Price 331 Handler 42	1 2	1 2	A4 A4(2)	
6. DUST COLLECTOR (BERYLLIUM, ETC)	Coe 6431	3	3	A4(3)	
7. OTHER CASTING MACHINES	Jelenko Thermotrol 2500	1	1	A4	
8. OTHER PROSTHETIC EQUIPMENT	None				
SECTION C - DENTAL X-RAY EQUIPMENT					
X-RAY UNIT	MANUFACTURER AND MODEL A	DATE OF RADIATION SURVEY B	NUMBER ON HAND C	NUMBER IN USE D	CONDITION CODE E
1. STATIONARY INTRA-ORAL	S. S. White Intrex May 1985	21 Nov 85	1	1	A4
2. MOBILE INTRA-ORAL	Philips Oralix 65 May 1984	21 Nov 85	1	1	A4
3. PANORAMIC	G. E. Panelipse April 1983	18 May 84	1	1	A4
4. CEPHALOMETRIC/ORTHOPANTOMOGRAPH	None				
5. PROCESSOR	Litton P-10 Air Techniques Perio Pro		1 1	1 1	A6 A4

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Figure 10-1C.—Dental Equipment and Facilities Report, NAVMED 6750/4—Continued.

that involve fixed units and removable partial and complete dentures. If providing prosthetic service to other facilities, list the activities who received support in the past year. List the average number of cases per month per activity, and submit it with the NAVMED 6750/4.

Part V, Remarks and Recommendations, provides space to continue remarks from other areas

of the report. It is also used to list all projects submitted to change spaces, military construction programs, or problem areas. Give the priority and status of each project. Indicate whether dental diagnostic x-ray units meet federal performance standards. Ships will provide a list of equipment programmed for replacement and give the programmed fiscal year. For entries in this part of

PART III - PROSTHETIC FACILITY DATA			
SECTION A - PROSTHETIC FACILITY / ATTACHED			
1. POTENTIAL CASE CAPACITY PER MONTH			25
2. IS PROSTHETIC SERVICE PROVIDED TO OTHER FACILITIES?			NO
3. IS PRESENT PROSTHETIC FACILITY ADEQUATE?			NO
4. ARE TEETH PROCURED LOCALLY TO SUPPLEMENT DEPOT STOCK?			YES
SECTION B - PROSTHETIC FACILITY NOT ATTACHED			
1. NAME OF PROSTHETIC FACILITY USED			N/A
2. DISTANCE, TIME AND MODE OF TRAVEL TO 1. ABOVE			N/A
3. AVERAGE NUMBER OF PROSTHETIC PATIENTS SEEN MONTHLY			N/A
4. NUMBER OF PATIENTS AWAITING PROSTHETIC TREATMENT			N/A
PART IV - UTILITIES			
1. ELECTRIC CURRENT	<input checked="" type="checkbox"/> AC	<input type="checkbox"/> DC	a. VOLTAGE 110/220 b. CYCLES 60
2. GAS	<input checked="" type="checkbox"/> NATURAL	<input type="checkbox"/> COMMERCIAL	<input type="checkbox"/> BOTTLED <input type="checkbox"/> ACETYLENE
PART V - REMARKS AND RECOMMENDATIONS			
<p><u>Part I, Line 1, 10, 18, 19</u></p> <p>CR 180 Special Project submitted to enlarge two DTR's, admin. office, and the enlisted male and female locker rooms. Design complete, construction funded for FY87.</p> <p><u>Part I, Line 7</u></p> <p>C280 Special Project submitted to enlarge lab and provide ventilation/exhaust for work spaces. Design complete, waiting for NAVMEDCOM funding action.</p> <p><u>Part II, Section B</u></p> <p>Prosthetic laboratory will receive new equipment when Special Project C280 is completed.</p> <p><u>Section C</u></p> <p>Litton X-ray Processor funded for OPN replacement FY87. Dental x-ray units meet federal performance standards.</p> <p><u>Part III, Line 3</u></p> <p>C280 Special Project will correct deficiencies in lab size and ventilation/exhaust system that doesn't work.</p>			
DATE	TYPED NAME AND GRADE	SIGNATURE	
1 January 1987	L. W. DENTIST, CAPT, DC, USN	<i>L. W. Dentist</i>	

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U.S. Government Printing Office: 1986-708-612/15841 2-1

Figure 10-1D.—Dental Equipment and Facilities Report, NAVMED 6750/4—Continued.

the report, follow the format shown in figure 10-1D.

Submit the original of the NAVMED 6750/4 to the Commander, Naval Medical Command (COMNAVMEDCOM). Annual reports must reach COMNAVMEDCOM no later than 10 January.

A newly constructed facility shall submit blueprints or schematic plans with the NAVMED

6750/4. If you are reporting because of completion of major facility alterations, submit an up-to-date NAVMED 6750/4 only.

DIRS TREATMENT REPORT

The *Dental Information Retrieval System (DIRS)* is a computer system that collects and

processes data on treatment provided to dental patients. As such, it helps Dental Corps managers plan personnel and material requirements.

The DIRS Treatment Report, NAVMED 6600/8, is a monthly statistical report required of all ships and stations having dental personnel. It is a coded report of all clinical and dental laboratory procedures performed by dental care providers. The report also provides for data on the number of dental officers per treatment facility, and for semiannual reporting of patient dental classifications.

The DIRS Treatment Report is assigned report symbol **MED 6600-6** for identification and control purposes. Be sure to cite the report symbol on all correspondence concerning this report.

PREPARATION OF NAVMED 6600/8

The NAVMED 6600/8 (figure 10-2) is a three-part, carbonized, optical character recognition (OCR) document. Because the report is machine-read, preparation instructions are very specific. To avoid errors and possible rejection by the OCR machine, refer to the detailed instructions in the DIRS Manual, NAVMEDCOMINST 6600.1 series. The following is only an outline of those instructions.

General Typing Instructions

Type each block on the NAVMED 6600/8 using an OCR-A typewriter element. Ensure that the typewriter pitch is set at 10 and that the form is properly aligned. All entries must fit within their boxes. Entries outside the boxes (in the red shading) will not be read by the OCR machine.

Use the alignment blocks to help align the form in the typewriter. Immediately after inserting it, locate the alignment block to the left of the UIC data block and the one to the right of the page data block. Type the letter "L" directly over the printed "L" in both blocks. When you reach the center of the form, use the center alignment blocks to ensure that the form remains properly positioned. Again, type "L" in each block.

Data Block Entries

Your activity's UIC and the report period must appear. Type the UIC provided in the DIRS Manual and type the report period as month and year. Enter three alpha characters for the month and two digits for the year, with no space between

the month and year; e.g., SEP86. A space will cause rejection of the form by the OCR scanner.

Enter only your activity's name as listed in the DIRS Manual—not the mailing address, zip code, or a title (e.g. Dental Service). If reporting for a naval dental clinic (NDC) headquarters clinic, include the activity's full name; e.g., HEAD-QUARTERS CLINIC SAN DIEGO CA. You may abbreviate the word headquarters (HQTRS) if the full name will not fit.

MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) CODE.—is the combination of Uniform Chart of Accounts (UCA) and Uniform Staffing Methodology (USM). MEPRS codes are required for all reports submitted by NAVMEDCOM, naval hospitals, and naval dental commands only.

The MEPRS codes consist of a four letter alphabetical code (alpha-code). A separate NAVMED 6600/8 must be submitted for each reporting center. Enter the alpha-code on forms submitted by each clinical location (work center). The MEPRS Codes are used to complete the block on the NAVMED 6600/8 labeled "UCA" Codes. These codes are issued to each reporting center by their MEPRS coordinator."

Codes with the first two letters of "CA" represent clinical procedures, while "CB" represents type 3 laboratory procedures and "CC" represents type 2 laboratory procedures. The third letter will always be "A". The fourth letter identifies the specific work center providing dental care. For example, listed below are the MEPRS codes assigned for clinical procedures performed by branch dental clinics of NDC, San Diego:

	WORK CENTER CODE	MEPRS CODE
Branch Clinic Naval Station	A	CAAA
Branch Clinic Naval Training Center	I	CAAI
Branch Clinic Marine Corps Recruit Depot	K	CAAK
Branch Clinic NAS Miramar	J	CAAJ
Branch Clinic NAS North Island	O	CAAO

The MEPRS code **CAAA** is used only by NDC headquarters clinics and naval hospitals. Letters "B" through "H" may be used for reporting work performed in NDC headquarters' department specialties. The letters "I" through "Z" must be used for echelon 5 and 6 activities.

CLASSIFICATION OF ACTIVE DUTY.—These blocks relate to active duty personnel whose dental records are maintained by your DTF. Report this data semiannually, in March and September. Count all records and enter actual numbers in each dental classification block. Do not report percentages of records per classification. You may enter up to five characters in these data blocks. Do not use any commas.

DENTAL OFFICERS.—Enter your DTF's dental officers as full-time equivalents (**FTE**). For DIRS purposes, one FTE (or man-month) is 168 man-hours. Use two decimal places; e.g., 10.89, 09.89, 9.00. Include Ready Reserve personnel at your DTF who are on temporary active duty, active duty for training, or scheduled drill periods.

DATA BLOCKS A, B, AND C.—Leave blank.

ORIGINAL, CORRECTION, RESUBMISSION.—Type the letter "X" in the appropriate block. An **ORIGINAL** is the first submission for a reporting period. A **CORRECTION** is a submission to add or delete data or to correct errors detected locally or by the OCR scanner. When submitting a correction, type only applicable changes; do not duplicate data already reported.

BENEFICIARY CODE.—Enter the appropriate two-digit number in the beneficiary code blocks. Beneficiary codes identify the types of patients who received the treatment being reported. These codes are as follows:

- 01 - Active duty, U.S. Navy
- 02 - Active duty, U.S. Marine Corps
- 05 - All other active duty, U.S. Uniformed Services personnel
- 08 - U. S. Navy or Marine Corps recruits (Enlisted)
- 09 - Dependents of active duty U.S. Uniformed Services personnel
- 10 - Dependents of retired or deceased U.S. Uniformed Services personnel
- 11 - Retired Uniformed Services personnel
- 12 - All other personnel not included in the codes 01 through 11 and 13
- 13 - Dependent children (unmarried, 17 years old or younger)

TREATMENT CODES AND TOTALS.—In the treatment code column, enter the four-digit clinical or laboratory services code for the

treatment performed. These codes are listed in chapters 4 and 6 of the DIRS Manual. When treatment is provided by a Ready Reserve dental officer, add the letter "R" after the treatment code, (e.g., 0120R). If treatment is provided by contract dentists, the letter suffix "C" must be placed after the treatment code (e.g., 0120C). Enter the total number of procedures for each treatment code in the proper beneficiary code column. The maximum number of digits is four per data block. If the total number of procedures exceeds four digits, repeat the treatment code on the next line. Enter the remaining number of procedures in the appropriate beneficiary column. **DO NOT** use the last column (far right column) on the form for line totals, because this column is not read by the OCR scanner. An entry in the final column, without a beneficiary code above it, will generate an error listing.

SUBMISSION OF NAVMED 6600/8

Submit the original of the NAVMED 6600/8 to COMNAVMEDCOM, to reach COMNAVMEDCOM by the 15th day of the month following the month reported on. Do not fold, clip, tape, or staple the forms. When mailing the report, use a 9 1/2 × 12 inch envelope, stiffened with cardboard. Mark the envelope "**PRIORITY MAIL/DO NOT OPEN IN MAIL ROOM.**"

If reporting for an NDC or naval hospital, you must also forward copies of the report to the appropriate geographic NAVMEDCOM. If reporting for a ship, Fleet Marine Force unit, or mobile construction battalion, forward copies to the appropriate force dental officer (SURFPAC, AIRLANT, FMFLANT, etc.).

Retain one carbon copy of each form submitted until you receive the monthly summary reports. Compare the monthly summary reports with your carbon copies. Destroy the carbon copies only after you have reconciled your report with the summary reports.

STATEMENT AND INVENTORY OF PRECIOUS AND SPECIAL DENTAL METALS

The Statement and Inventory of Precious and Special Dental Metals, NAVMED 6630/3, is a monthly internal report; i.e., one that is submitted only to your commanding officer. It is used to report the quantity of highly valuable (precious) and alloyed (special) metals received, used, and

remaining on board your dental activity. Because these metals are used to fabricate dental prostheses, the report is prepared only by activities with dental prosthetic capabilities.

Because of the high value of precious and special dental metals, strict measures are employed to account for them. The NAVMED 6630/3 is only a small part of these measures. The Prosthodontic Work Request and Prescription, NAVMED 6630/1, and the Precious Metal Issue Record, NAVMED 6630/2, also help account for these metals. A precious and special dental metals audit board reviews all receipt, issue, use, and disposition records. Board members conduct a physical inventory of all precious and special metals within the activity and compare their records with the NAVMED 6630/3 each month. Discrepancies, if not reconciled, may result in disciplinary actions.

The NAVMED 6630/3 may be only an internal report, but that does not lessen its importance. Always ensure that all entries are accurate and appropriately documented.

PREPARATION OF NAVMED 6630/3

Complete all applicable items on the NAVMED 6630/3 as directed in article 6-156 of the *Manual of the Medical Department (MANMED)*. Entries may be typewritten or made by hand with black ink. You can see a sample form in figures 10-3A and 10-3B. The following paragraphs highlight the MANMED requirements. If an item on the form is not mentioned, it is self-explanatory.

Entries on the NAVMED 6630/3

At the upper left, after "ACTIVITY," enter the name of your ship, station, or dental activity in capital letters. Then, for a shore station, give the city in small letters and the state in capital letters. If you're aboard a ship or foreign shore station, follow your activity's name with its post office address.

Enter the sum of columns 3 and 4 in column 5. Precious metals are measured in troy weight, with one pennyweight (dwt) equaling 24 grains (gr). Do not add quantities as if they were numbers in the decimal system. Convert to pennyweights as necessary. For example:

$$\begin{array}{r} 60 \text{ dwt } 00 \text{ gr} \\ + 20 \text{ dwt } 21 \text{ gr} \\ + 15 \text{ dwt } 12 \text{ gr} \\ \hline 95 \text{ dwt } 33 \text{ gr} = 96 \text{ dwt } 09 \text{ gr} \end{array}$$

Because 1 dwt equals 24 gr, the 33 gr in the total above must be converted to 1 dwt 09 gr. Your total, therefore, would be 96 dwt 09 gr.

In column 6, "MISCELLANEOUS," enter quantities of metals used for technique practice, or lost due to grinding or miscasting. Explain all entries in this column on the reverse of the form.

For column 8, subtract the combined total of columns 6 and 7 from column 5. Convert grains to pennyweights as necessary. Convert pennyweight to grains as shown in the following example:

$$\begin{array}{r} 75 \text{ dwt } 06 \text{ gr} \\ -4 \text{ dwt } 19 \text{ gr} \\ \hline 70 \text{ dwt } 11 \text{ gr} \end{array} \quad \begin{array}{l} \text{to} \\ -4 \text{ dwt } 19 \text{ gr} \\ \hline 74 \text{ dwt } 30 \text{ gr} \end{array}$$

Because you cannot subtract 19 gr from 06 gr, convert 1 pennyweight to 24 gr. This changes 75 dwt 06 gr in form—not amount—to 74 dwt 30 gr. Your total, therefore, would be 70 dwt 11 gr.

For column 13, enter the total of columns 9, 10, 11, and 12. Make weight conversions as necessary. When finished, your entries in column 8 and column 13 must match.

Block 14 is completed by the precious and special metals custodian who then submits the form to the audit board. The audit board reviews precious and special metals records, conducts their inventory, and reviews, dates, and signs the NAVMED 6630/3. The board makes pertinent comments on the reverse of the form and submits it to your commanding officer for signature approval.

DISPOSITION OF NAVMED 6630/3

File the original of the signed NAVMED 6630/3 in monthly sequence in your activity's file. This file must be available for inspection at any time until disposed of. Presently, the forms must be held on board your activity for 2 years. Refer to SECNAVINST 5212.5 series for exact disposition instructions.

REPORTS MANAGEMENT

Reports management ensures that reports provide information effectively and efficiently. As an advanced dental technician, you may be designated as your activity's reports manager. Because reported information can affect your

<i>Explanation of expenditures of precious and special dental metals from Column 6 on other side</i>	<i>Comment and recommendation by audit board</i>
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

NAVMEC 6630/3 (12-72) (BACK)

U.S. GOVERNMENT PRINTING OFFICE: 1968 - 605 009 35115

Figure 10-3B.—Statement and Inventory of Precious and Special Dental Metals, NAVMED 6630/3—Continued.

activity's personnel, financial, and mission status, you must take reports management functions seriously. Refer to **NAVMEDCOMINST 5210.1** series (Forms, Reports, and Records Management Program) for more information concerning reports management responsibilities. Your duties may be to:

- Develop (or assist in the development of) an activity reports management directive. Your directive must include a complete tabulation of all local reporting requirements and those of higher authority. Prepare the tabulation using the format shown in **MANMED**, Chapter 23. You need not include COMNAVMEDCOM reporting requirements since they are already tabulated in **MANMED**.
- Establish a separate reports file (project folder) for each local report. Conduct an annual review of the reports to evaluate need and possible improvement, revision, or elimination. Normally, you will perform this function only when assigned to a large dental activity that requires reports from subordinate activities.
- Ensure that reports required of your activity are submitted on time, conform to reporting requirements, and contain accurate information. This duty is one that you are required to understand and fulfill. The following paragraphs define the requirements.

TICKLER FILE

As mentioned earlier, failure to submit required reports reflects negatively upon your activity. To ensure timeliness, activities normally establish a reports control system, e.g., tickler file.

A tickler (reminder) file is an index of recurring reports required of your activity, and which contains information concerning report identification, preparation, and submission.

Recurring reports are of two types: periodic and situational. Periodic reports are submitted at regular intervals (weekly, monthly, quarterly, etc.) and convey essentially the same type of information each time. The reports discussed earlier in this chapter are periodic reports. Situational reports are prepared upon the occurrence of an event or situation, e.g., an accident or equipment survey.

Tickler File Contents and Use

The contents of a tickler file may vary at each activity. Usually, it is a card file containing 5 × 8 inch recurring report cards (figure 10-4) and indicator tabs or separators. The separators are labeled to reflect when reports are to be submitted, e.g., January through December; Situational. If you receive a new reporting requirement, simply complete a recurring reports record card and file it by its submission date.

To enable you to submit situational reports without unnecessary delay, keep abreast of reporting requirements so you are familiar with events that warrant such reports.

SUMMARY

Reports are required of all dental activities. They generally inform others of specific situations or events, provide required information, and/or record data for future use. Reports management and control ensures that your activity's reporting requirements are met.

The Dental Equipment and Facilities Report, the DIRS Treatment Report, and the Statement and Inventory of Precious and Special Dental Metals are recurring reports required of most dental activities. The first two provide data for developing dental logistic plans and budget requests and determining personnel and material requirements. The metals report is an internal report that serves as an account of dental metals used to fabricate dental prostheses. Prepare all reports carefully and ensure that the information they contain is accurate and meets reporting requirements.

REFERENCES

- NAVMEDCOMINST 5210.1 series, *Forms, Reports, and Records Management Program*, November 1984
- NAVMEDCOMINST 6600.1 series, *Dental Information Retrieval System (DIRS) Manual*, September 1987
- NAVMEDCOMINST 6750.1 series, *Dental Equipment and Facilities Report*, March 1984
- OPNAVINST 5214.7 series, *Department of the Navy Reports Management Program*, February 1983
- Manual of the Medical Department*, NAVMED P-117, Chapter 6, July 1987 (through change 101)

1. REPORT SYMBOL	2. TITLE	3. FORM NUMBER	4. TICKLER DATE
5. PERIOD COVERED OR AS OF DATE		6. MAILING DATE	
7. OFFICE PREPARING REPORT			
8. PERSON TO CONTACT		9. TELEPHONE EXTENSION	
10. DISTRIBUTION (Original, copies, v.s., etc.)			
11. DIRECTIVES (Bureau and local)			
12. SPECIAL COMMENTS			

Figure 10-4.—Recurring report record card.

CHAPTER 11

CLINICAL SUPERVISION AND ADMINISTRATION

Learning Objectives

Upon completion of this chapter you will be able to:

1. Recognize the principles of effective personnel management.
2. Identify personnel evaluation requirements and procedures.
3. Identify dental records management requirements and procedures.
4. Identify dental infection control program requirements and procedures.
5. Identify occupational health safety program requirements and procedures.
6. Identify dental equipment preventive maintenance program requirements.
7. Identify the purpose and requirements of the precious metals recovery program.
8. Identify the purpose and activities of the quality assurance program.
9. Identify patient administration programs and procedures.

INTRODUCTION

As an advanced dental technician, you may be the leading petty officer in a department or clinic. As such, you will assist your department head or clinic director in planning, coordinating, and directing personnel functions and dental programs. Stated simply, you may serve as an assistant administrator or manager.

This chapter discusses the basic management principles and is designed to help you perform your supervisory and management responsibilities. Since you, as leader and supervisor, must evaluate your personnel, this chapter also covers enlisted performance evaluations. The final sections cover the dental programs you may be asked to help administer.

Good managers come in many forms and use a variety of management styles. Whatever your personality, you can be a good manager. Learn all you can about the people and the programs you direct and coordinate. Managing can be a satisfying job when you are prepared to meet its challenges.

PRINCIPLES OF MANAGEMENT

Management has been defined in many ways, but most definitions include the concept of using personnel and resources to attain predetermined goals. Its primary objective is the successful and efficient accomplishment of an organization's mission.

As manager, you will plan, organize, direct, and control a dental department or clinic operation. These management functions are discussed in the following paragraphs.

PLANNING

Like most management functions, planning can be approached in different ways and can be broken down into steps. Planning involves setting your objectives and outlining your courses of action.

Your activity's goals can be derived from mission statements, command directives, and people in higher authority or within the department or clinic. As manager, take these goals and establish clear, specific work objectives. Relevant work

objectives that are understood and accepted by workers will lead to efficiency and cooperation. Just like the learning objectives you develop for training, work objectives provide direction and inform personnel what is expected of them. Specific objectives, such as quality and quantity standards and production deadlines, let people know what to do, when to do it, and what progress has been made.

Before planning your course of action, ask your subordinates for their input regarding your work objectives. Mutual goal-setting by you and your personnel promotes good working relationships and increases motivation and performance.

Having all the facts and set work objectives, you can now plan courses of action to achieve your objectives. First, identify the factors that confine or guide your actions such as time and personnel available, personnel skill levels, operating schedules, command policies, and funds. Then try to outline two or more possible courses of action. This will force you to consider all options rather than planning only a single course of action.

Review your courses of action to ensure that they are feasible. You may find it beneficial to combine two or more courses of action. If the plans must go to higher authority for approval, ensure that your plans are complete and properly explained. Planning ends once the objectives and courses of action are developed.

ORGANIZING

Once your objectives and courses of action are set, your next step is to distribute the work. A part of organizing is the matching of people to jobs to ensure maximum performance and job satisfaction. Every job must be assigned, the "once-in-awhile" jobs as well as the daily jobs. Ask yourself these five questions when assigning people to jobs:

1. Which person has the capabilities and skills to accomplish which job?
2. Is additional training necessary?
3. Must I delegate additional authority or make adjustments within the department or clinic?
4. What is each person's preference for a job assignment?
5. Are outside activities or departments involved in accomplishing my objectives?

When assigning jobs, ensure that your people have a thorough knowledge of all procedures

involved. Remember, you have a responsibility to train all personnel to perform their duties according to their rates. Give similar or related tasks to the same person. A proper combination of duties speeds up the operation by eliminating wasted motion. Divide the workload as fairly as possible. Don't make the common mistake of having your most productive personnel doing all the work. Uneven workload lowers morale. See that all hands share the work load.

Assign the responsibility for each job to one specific person. Larger jobs may require several people, but assign one person the responsibility for overall accomplishment. (But remember, you can't delegate the *ultimate* responsibility.) Match responsibility with authority. Give people sufficient authority and avoid interfering needlessly so they will feel free to get the job done.

One final note on organizing: Although your department or clinic may have a relatively simple chain of command, it is still important to have a well-defined organizational structure. All personnel should know their job assignments and the extent of their authority. This doesn't mean they can't help each other or be reassigned when necessary.

SUPERVISING

Your job is not completed when you make work assignments. The work must be directed and controlled to ensure that your plan is adequate and your objectives are being met. To do this, you must supervise your personnel, overcome any unexpected obstacles, check results, and correct discrepancies and misunderstandings when necessary.

Because of your prior exposure to manuals and courses that cover supervisory functions, this chapter does not provide a detailed discussion of supervision.

The way you supervise depends upon your people, the type of work involved, the work environment, and your management style. You must ensure that your people are adequately trained and regularly inspected, and that you realistically evaluate their performance.

PERSONNEL EVALUATIONS

As a leader and manager, you are constantly evaluating your people on how well their work assignments are performed, individually and with others. Through evaluation you can identify the

best worker for each job and recognize people with the most potential for accepting increased responsibility. Regular performance evaluation and counseling are both productive and necessary.

The *Navy's Enlisted Performance Evaluation System*, as outlined in **NAVMILPERSCOMINST 1616.1** series, is designed to make personnel evaluations more equitable. The system provides guidance on evaluating personnel and preparing evaluation reports. Although your commanding officer is responsible for all evaluations, you are a supervisor and are tasked with preparing the initial evaluation of your junior personnel. Since the following discussion of enlisted performance reports is only a summary, you must consult **NAVMILPERSCOMINST 1616.1** series, before preparing evaluation reports.

The Enlisted Performance Evaluation Report (NAVPERS 1616/24) is a periodic record of an individual's performance in comparison to peers, and his conduct, qualifications, and potential for increased responsibility. It is a significant management tool used to:

- Make personnel advancement and assignment decisions
- Determine eligibility for the Good Conduct Medal, reenlistment, and character of service at discharge
- Select personnel for appointment to commissioned status and assignment to special duties and education programs

The importance of enlisted performance evaluation reports cannot be overemphasized. These reports require careful attention and responsible action on your part. Throughout the reporting period, your personnel should be counseled regularly on their professional growth and development, and provide them positive feedback. If necessary, discuss specific weaknesses and provide suggestions for improvement. Evaluate your personnel uniformly; i.e., evaluate each person without bias and within the same guidelines. Evaluate individuals within a paygrade against the performance of others in the same paygrade. Mark them in grades that most nearly reflect their performance, knowledge, ability, attitude, or appearance. Your commanding officer, department head, or division officer generally provides guidelines for report development. Stay within these guidelines and keep in mind that the report is for an entire period, not just for the few days preceding the evaluation.

DENTAL RECORDS MANAGEMENT

As discussed earlier, dental records must be protected and preserved. They are of continuing interest to the patient and the U.S. Government in determining eligibility for future care and in resolving claims or other medicolegal questions. A dental records management program ensures that these records are properly prepared, maintained, handled, transferred, and retired.

Should you be appointed as your DTF's dental records administrator, you must be thoroughly familiar with the contents of the following references:

- **NAVMEDCOMINST 6150.1** series, *Health Care Treatment Records*. This instruction sets forth administrative management policies and procedures for dental records.
- **SECNAVINST 5211.5** series, *Personal Privacy and the Rights of Individuals Regarding Records Pertaining to themselves*. This instruction prescribes policies, conditions, and procedures for collecting, safeguarding, using, and disseminating personal information contained within the dental records.
- **SECNAVINST 5212.5** series, *Department of the Navy Records Disposition Manual*. This instruction prescribes retention and disposition standards for dental records.
- **NAVMED P-117**, *Manual of the Medical Department*, Chapters 6 and 16. This manual prescribes dental treatment forms and specific dental record entries.
- **NAVMEDCOMINST 6600.2** series, **NAVMED 6600/3**, *Dental Health Questionnaire*. This instruction provides guidance for the use of the revised Dental Health Questionnaire.

The following paragraphs cover the custody, chargeout control, transfer, and retirement of military and outpatient dental treatment records. Refer to *Dental Assistant, Basic*, **NAVEDTRA 10677.B**, to review dental record preparation, contents, verification, and filing procedures. Refer to chapter 3 of this manual to review policies concerning the release of information from dental records.

CUSTODY OF DENTAL RECORDS

Dental treatment records and their contents are the property of the Federal Government. They must be retained in a medical treatment facility (MTF) or DTF. Patients must never maintain custody of their own dental records. As a DTF dental records administrator, you must ensure that this policy is strictly enforced.

INTERNAL CHARGEOUT CONTROL OF DENTAL RECORDS

The removal of dental records from your DTF's files must be controlled and carefully accounted for. The Health Record Receipt, NAV-MED 6150/7, provides a means for such chargeout control.

For effective chargeout control, ensure that the following information is recorded on the form:

- Family member prefix code and social security number (SSN) (sponsor's SSN for dependents)
- Patient's name
- Patient's grade or rate, and ship or station (home address for retired personnel; sponsor's information for dependents)
- Name of practitioner or clinic receiving the record
- Chargeout date. Ensure that completed forms are filed in terminal-digit sequence and that they are checked frequently to verify timely record returns. Dental records charged out from files must be returned as soon as possible, but should not be out for more than 5 working days. Develop some sort of followup procedure to recover delinquent dental records.

One final note about chargeout control of dental records. In the past, it was common for patients needing treatment outside your activity to chargeout and hand carry their dental record to another DTF or MTF. This practice is not recommended and should be minimized. Whenever possible, ensure that the dental records are charged out in advance of appointments directly to the facility providing care.

Chargeout Guide

A chargeout guide is simply a plastic folder with pockets. A folder with two pockets is more convenient and efficient, one pocket to hold the chargeout form, the other to hold loose treatment forms that are received while the dental record is charged out.

Chargeout guides are available in various colors. In developing your chargeout control procedures, you may find it helpful to use a color coding system. For example, a particular color can denote a particular day or week the record was charged out from the file. This provides a quick reference to determine how long records have been charged out, and facilitates followup and retrieval of the records.

TRANSFER AND RETIREMENT OF MILITARY DENTAL RECORDS

Military dental records are transferred on a permanent or temporary basis. In either case, a Record of Transfer must be prepared and maintained. Temporary transfers are accomplished through chargeout control. Permanent transfers are discussed below.

Permanent Transfer

The member's Personnel Officer or Personnel Support Detachment (PSD) requests the transfer of the member's dental record using the Request for Medical/Dental Records, DD Form 877 (figure 11-1). When you receive a DD Form 877, take the following steps:

1. Pull the requested dental record from your files and verify it. If no record is in the file, establish a new record jacket. Insert a new SF 603 and make the following entry in block 17: "Treatment Record Jacket opened this date. No other treatment records available at (your DTF's name and address)." Be sure to date the entry.
2. Complete the appropriate blocks on the DD 877. If a secondary record exists, insert the following statement in block 9: "Member has secondary treatment record which accompanies primary treatment record." Pull the first copy of the completed DD 877 and file it in the primary treatment record.
3. If a secondary treatment record exists, place it in an envelope. Seal and stamp

REQUEST FOR MEDICAL/DENTAL RECORDS OR INFORMATION		REQUESTING ACTIVITY - Complete items 1 through 10/Except 8b). also complete item 10.	DATE																						
1. PATIENT (Last Name - First Name - Middle Name): CECIL, LAURIE AGNUS		ADDRESSEE - Complete items 8b, 11 to 14 or 15 to 18, as appropriate. Final referer shall return to requester.																							
2. ORGANIZATION AND PLACE OF TREATMENT: Naval Station, San Diego, CA 92136-5147		3. STATUS <input checked="" type="checkbox"/> MILITARY <input type="checkbox"/> VA BENEFICIARY <input type="checkbox"/> DEPENDENT <input type="checkbox"/> FEDERAL EMPLOYEE <input type="checkbox"/> OTHER (Specify)																							
4. TO: (Include ZIP Code) [Commanding Officer Naval Dental Clinic Norfolk, VA 23511]		3a. NAME OF SPONSOR (If dependent)																							
5. DATES OF TREATMENT (Inclusive): Jul 86-Aug 87		6. IDENTIFYING INFORMATION																							
		a. SERVICE NUMBER																							
		b. GRADE/RATE AG1																							
		c. SOCIAL SECURITY ACCOUNT NO. 20-399-64-8346																							
		d. VA CLAIM NUMBER																							
		e. DATE OF BIRTH (If Federal employee) 2 Jan 57																							
7. DISEASE OR INJURY		8. RECORDS REQUESTED																							
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REPLY/REFERRAL																									
11. TO:		12. REMARKS																							
13. SIGNATURE		<input type="checkbox"/> RECORDS CHECKED IN 8b FORWARDED <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED FURNISH FOLLOWING:																							
14. DATE																									
REPLY/SECOND REFERRAL																									
15. TO:		16. REMARKS																							
17. SIGNATURE		<input type="checkbox"/> RECORDS CHECKED IN 8b FORWARDED <input type="checkbox"/> NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD. <input type="checkbox"/> MORE INFORMATION NEEDED FURNISH FOLLOWING:																							
18. DATE																									
19. RETURN TO: (Include ZIP Code) [Naval Dental Clinic Naval Station Box 147 San Diego, CA 92136-5147]		REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.																							

Figure 11-1.—Request for Medical/Dental Records DD 877.

the envelope "FOR OFFICIAL USE ONLY - NOT TO BE RELEASED TO PATIENT."

4. Place both records in another envelope and seal it.
5. Pull and fold the original DD 877 and place it in a window envelope so the mailing address shows through. Seal the envelope and

tape it over the flap of the envelope containing the treatment records. Forward by United States Postal Service mail or local/courier service.

6. File the second copy of the completed DD 877 in an alphabetic file as a record of transfer. Maintain the DD 877 for 1 year after the date of transfer and then destroy as directed in SECNAVINST 5212.5 series.

Retirement

DTF's do not retire primary military dental treatment records. Such action is accomplished by the Commander, Naval Military Personnel Command, the Commandant of the Marine Corps, or one of their field activities. As a result, your involvement in this area is the same as discussed above for permanent transfer of the dental record.

TRANSFER AND RETIREMENT OF OUTPATIENT DENTAL RECORDS

Outpatient dental records are those that record dental care provided to all patients who are not members of the uniformed services. These patients normally are space-available beneficiaries. Transfers of these records are also considered either permanent or temporary, and require a record of transfer. In contrast to military dental records, outpatient records may be retired by DTFs.

Because of the differences in the transfer and retirement of outpatient records vice military records, each is discussed below. Please remember that the following procedures apply only to outpatient dental records.

Permanent Transfer

You may permanently transfer outpatient dental records only upon the sponsor's or family member's change of residence. When outpatient records are requested, provide the sponsors or family members one DD 877 for each record to be transferred from your facility. Ensure that your DTF's mailing address appears in block 4 (the "To" block) of all copies of the form. Instruct them that after arrival at their new residence they should complete and submit the DD 877 forms to the new DTF. The new DTF will assist them in completing the form(s).

Upon receipt of a DD 877 for outpatient dental records held at your DTF, take the same action as described under Permanent Transfer of the Military Dental Record. Be sure to complete block 19 (Return To:) for the DD 877. **NOTE:** The procedures just described represent a departure from past practices. They are designed to facilitate dental care to outpatients. At the same time, they provide maximum protection against loss or misfiling of records.

Temporary Transfer

The temporary transfer of outpatient records is accomplished for consultation of specialty treatment purposes. Record such transfers on internal chargeout cards in the same manner as described for military dental records. Remember, hand carrying of dental records by patients is discouraged. Make every effort to transfer the record directly to the requiring DTF.

If the record must be hand carried, use the Outpatient Record Release Request and Transfer Receipt, NAVMED 6150/8, as shown in figure 11-2 to record the event. Ensure strict compliance with the instructions on the form. Before you release the record, seal it in an envelope and, tape the NAVMED 6150/8 over the envelope's flap.

Release of Dental Radiographs

Because outpatients receive only space-available treatment, they often seek dental care from civilian dentists. To prevent unnecessary x-ray exposure, dental x-rays may be released to a space-available beneficiary for a civilian dentist's use. However, they shall remain the property of the U.S. Navy (mark radiograph mounts and/or envelopes containing films as such).

When you release dental radiographs, make a dated entry on the current SF 603. Record the requester's name and state that the radiographs have been loaned to the requester (e.g., 12 Jul 87, Mrs Mary Jones requested loan of bitewing radiographs exposed on 10 Jan 87. Bitewing loaned this date). Sign the entry and instruct the requester to sign also. Remember, both the requester and the provider must sign when the radiographs are released. In addition, maintain a log of all released radiographs indicating the following:

- Date of release
- Patient's name
- Sponsor's SSN
- Type and quantity of radiograph(s)
- Requester's signature

OUTPATIENT RECORD RELEASE REQUEST and TRANSFER RECEIPT NAVMED 6150/8 10-781 S/N 0105 L# 206 1540	
<p>I REQUEST TO HAND-CARRY RECORDS BY SPONSOR SPOUSE OR OTHER ADULT DEPENDENT</p> <p>I REQUEST TO HAND-CARRY AND ACKNOWLEDGE RECEIPT OF THE OUTPATIENT TREATMENT RECORD INDICATED IN PART II. I UNDERSTAND THAT IF THIS RECORD IS LOST OR MISPLACED A DUPLICATE RECORD CANNOT BE FURNISHED.</p> <p>I CERTIFY THAT I WILL DELIVER THIS RECORD TO THE MEDICAL FACILITY WHICH WILL PROVIDE SUBSEQUENT CARE AND TREATMENT.</p> <p>I UNDERSTAND THIS RECORD IS TO BE OPENED ONLY BY THE DESTINATION MEDICAL FACILITY. I ALSO UNDERSTAND THAT THIS RECORD MAY BE GIVEN TO ANOTHER MEDICAL FACILITY, PRIVATE PHYSICIAN OR CIVILIAN HOSPITAL FOR USE IN RENDERING CARE AND TREATMENT SHOULD THE NEED OCCUR WHILE TRAVELING.</p> <p>DATE _____ SIGNATURE (SPONSOR SPOUSE OR OTHER ADULT DEPENDENT TAKING CUSTODY OF RECORD) _____</p> <p>RELATIONSHIP TO SPONSOR _____</p>	<p>III AUTHORIZATION BY SPOUSE, OTHER ADULT DEPENDENT</p> <p>I AUTHORIZE THE PERSON NAMED IN PART I TO TAKE CUSTODY OF MY OUTPATIENT TREATMENT RECORD INDICATED IN PART II FOR THE PURPOSE OF HAND-CARRYING THIS RECORD TO THE MEDICAL FACILITY WHICH WILL PROVIDE SUBSEQUENT CARE AND TREATMENT.</p> <p>DATE _____ SIGNATURE (SPOUSE, OTHER ADULT DEPENDENT) _____</p> <p>RELATIONSHIP TO SPONSOR _____</p>
<p>II PATIENT IDENTIFICATION DATA (USE OUTPATIENT RECORDING CARD, IF TYPE OR PRINT.)</p> <p>1. DEPENDENT'S NAME - LAST, FIRST, MIDDLE INITIAL, DATE OF BIRTH, SEX, RELATIONSHIP TO SPONSOR</p> <p>2. SPONSOR'S NAME - LAST, FIRST, MIDDLE INITIAL, SSN, GRADE, RATE, BRANCH OF SERVICE</p>	<p>IV FACILITY DATA (PRINT OR TYPE NAME AND ADDRESS)</p> <p>1. TRANSFERRING MEDICAL FACILITY</p> <p>2. DESTINATION MEDICAL FACILITY (IF KNOWN)</p> <p>3. SPONSOR'S NEW DUTY STATION</p>
	<p>V RECEIVING MEDICAL FACILITY ACKNOWLEDGEMENT</p> <p>OUTPATIENT TREATMENT RECORDS RECEIVED</p> <p>RECEIVING FACILITY (PRINT, TYPE OR RUBBER STAMP NAME AND ADDRESS)</p> <p>DATE _____ SIGNATURE AND TITLE _____</p>

INSTRUCTIONS

NOTE: USE WITH MECHANICAL IMPRINTING EQUIPMENT IN PART II IMPRINT PATIENT IDENTIFYING DATA WITH THE PATIENT'S RECORDING CARD. COMPLETE OTHER PARTS OF THE FORM IN BALL POINT PEN OR BY TYPEWRITER. PREPARE IN DUPLICATE.

TRANSFERRING MEDICAL FACILITY ▶

- HAVE PARTS I, II, AND IV COMPLETED IN ALL CASES. ALSO PART III IF ANY ADULT DEPENDENT'S RECORD IS TO BE RELEASED TO THE SPONSOR, SPOUSE, OR OTHER ADULT DEPENDENT.
- RETAIN THE ORIGINAL. ATTACH DUPLICATE COPY TO DEPENDENT'S OUTPATIENT TREATMENT RECORD AND SEAL IN A POSTAGE AND FEES PAID ENVELOPE. ADDRESS TO DESTINATION MEDICAL FACILITY. IF KNOWN, PRINT OR TYPE PATIENT'S NAME IN LOWER RIGHT CORNER AND LABEL ENVELOPE.

**MEDICAL RECORDS - FOR PHYSICIAN'S USE ONLY U.S. GOVERNMENT PROPERTY
IF FOUND, MAIL TO ADDRESS SHOWN**

MEDICAL FACILITY IN TRANSIT ▶

IF THIS RECORD IS OPENED IN TRANSIT TO PROVIDE MEDICAL CARE, TREATMENT FORMS AND REPORTS SHOULD BE INCORPORATED WITH THE PATIENT'S RECORDS. RESEAL ENVELOPE AND RETURN TO BEARER.

PRIVATE PHYSICIAN, CIVILIAN HOSPITAL IN TRANSIT ▶

IF THIS RECORD IS OPENED BY YOU FOR USE IN PROVIDING MEDICAL CARE, PLEASE INCLUDE COPIES OF TREATMENT FORMS AND REPORTS WITH THE PATIENT'S RECORDS. RESEAL ENVELOPE AND RETURN TO BEARER.

RECEIVING MEDICAL FACILITY ▶

- COMPLETE PART V UPON RECEIPT OF OUTPATIENT TREATMENT RECORD INDICATED IN PART II.
- DELIVER DUPLICATE COPY OF NAVMED 6150/8 AS RECEIPT TO THE SPONSOR, SPOUSE, OR OTHER ADULT DEPENDENT.

Figure 11-2.—Outpatient Release Request and Transfer Receipt, NAVMED 6150/8.

Retirement of Outpatient Dental Records

Outpatient dental treatment records may become eligible for retirement due to inactivity. The record retirement tape (discussed in *Dental Assistant, Basic*) provides an easy means of determining records ready for retirement. Do not, however, retire records solely on the basis of the retirement tape. Review each record to ensure that it has been inactive for the required period of time

and try to verify the sponsor's duty station and location before retiring the record.

When outpatient records are retired, they are forwarded to:

National Personnel Records Center
Military Personnel Records
9700 Page Boulevard
St. Louis, Missouri 63132

Ensure compliance with procedures outlined in the *Records Disposition Manual, SECNAVINST 5212.5* series.

DENTAL INFECTION CONTROL PROGRAM

Dental personnel may be exposed to a wide variety of infectious microorganisms and associated diseases. Conversely, infectious agents may be transmitted from dental personnel to their patients. The primary goal of an infection control program is to eliminate the potential for such cross-contamination.

The *Dental Infection Control Manual (NAVMEDCOMINST 6600.3* series) provides comprehensive guidelines and procedures to prevent the transmission of infectious agents in the dental clinic. As a clinic supervisor, you must be thoroughly familiar with its contents and ensure that:

- Personnel are aware of the sources and methods of disease transmission
- Personnel are appropriately trained in infection control procedures and aseptic and sterilization techniques
- Personnel follow required procedures and take necessary precautions to protect themselves and their patients

GENERAL INFECTION CONTROL GUIDELINES

A common set of infection control strategies is used by all DTFs. Not all potentially infected patients can be identified by physical examination or readily available laboratory tests. Therefore, the guidelines below are used for the development of DTF infection control programs.

NOTE: This section merely highlights general guidelines. Your DTF's specific procedures are established through internal review, quality assurance/risk management, and occupational health safety programs.

Medical History Review

Each patient's medical history must be reviewed prior to any dental examination or treatment. Medical consultation may be necessary when a history of active infection or systemic disease is revealed. This requirement includes dental assistants who perform dental prophylaxis and expose dental radiographs. Although a patient may have recently been seen by a dental officer, a medical history review is still necessary.

Protective Attire and Barrier Techniques

Dental staff members must wear disposable gloves whenever they might come in contact with:

- Blood, saliva, or mucous membranes
- Any items (surfaces, intraoral appliances and devices, etc.) soiled by blood, body fluids, or secretions

When treatment is completed on a patient, you must wash your hands and reglove before treating another patient. Repeated use of a single pair of gloves is not recommended when performing definitive care. Such use is likely to produce defects in the gloves, and reduce the glove's value as an effective protective barrier.

Additional protective attire includes surgical masks, protective eyewear, reusable or disposable clinical apparel, and surface covers. Surgical masks protect your respiratory tract from aerosols and protect you from splashing or spattering of body fluids. Protective eyewear must be worn by both the dental staff and the patients to protect the eyes from harmful debris. Reusable or disposable smocks must be worn at all times when treating patients or when working in areas where contaminated materials may be present. Smocks should be changed daily, or when visibly soiled with blood or aerosols. Ensure that soiled linens are not removed from your DTF for cleaning in home laundries. Impervious backed paper, aluminum foil, or clear plastic wrap may be used to cover surfaces that may be contaminated by blood or saliva and are difficult to disinfect (e.g., light handles or x-ray tubeheads). While gloved,

remove the coverings and discard them; when you have changed your gloves, replace the covers between patients.

Hand Washing

Hand washing is the single most important procedure for preventing clinic-borne infections. Dental personnel must wash their hands:

- Prior to gloving
- Between patient treatment contacts (after gloves are removed)
- After touching inanimate objects likely to be contaminated
- Before leaving the dental treatment room (DTR). Plain soap and water is adequate for many routine dental procedures (exams, nonsurgical techniques). An antimicrobial surgical hand scrub is required for surgical procedures.

Disposing of Used Sharp Instruments and Needles

Used sharp items (needles, scalpel blades, etc.) must be considered a potential source of infection and must be handled with extraordinary care. Place these items in puncture-resistant containers, but handle them as little as possible to prevent cross-contamination.

Disinfection/Sterilizing

Surgical or other instruments that normally penetrate soft tissue or bone (e.g., forceps, scalpels, bone chisels, scalers, and surgical burs), and instruments that may contact oral tissue must be sterilized after use.

Presterilization cleaning can be accomplished by a thorough soap and water or detergent

scrubbing, by ultrasonic cleaning, or by using a washer sterilizer. Ensure that personnel who clean and decontaminate instruments wear heavy-duty gloves to prevent hand injuries and possible contamination. Autoclaving is appropriate for metal and heat-stable dental instruments. Dry-heat sterilization is appropriate when autoclaving is contraindicated.

High-level disinfection is appropriate for heat-sensitive instruments. It may be accomplished by immersing the instruments in a disinfectant or antimicrobial chemical solution for the manufacturer's recommended exposure time. In addition to their normal spectrum, such disinfectants must be classified tuberculo-cidal (lethal to tubercle bacillus microorganism) by the U.S. Environmental Protection Agency (EPA).

Disinfecting Environmental Surfaces and Laboratory Supplies and Materials

At the end of each work day, use absorbent towels to wipe countertops and other surfaces possibly contaminated. Then disinfect them with an EPA registered chemical disinfectant.

Intraoral appliances and laboratory materials that have been used in the mouth should be thoroughly and carefully cleaned and disinfected before they are:

- Handled, adjusted, or delivered to a dental laboratory
- Placed in the patient's mouth when returned from the dental laboratory

Sterilizing Dental Handpieces, Ultrasonic Scalers, and Dental Units

All surgical handpieces must be properly sterilized between uses. Ensure that other nonsterilizable handpieces (e.g., ultrasonic scalers, automatic condensing units, fiberoptic light/curing wands, air/water syringes) are treated consistent with their clinical application.

Disposing Potentially Infective Waste Materials

Identifying dental clinic wastes requiring special precautions is largely a matter of judgment.

The most practical approach is to identify wastes that present sufficient risk of causing infection during handling and disposal.

Consider all sharp items (especially needles), tissue, or blood as potentially infective. Ensure that these items are handled with special precaution. (All sharp items are placed intact into puncture resistant containers before disposal.) Blood, suctioned fluids, or other liquid wastes are carefully poured into drains connected to a sanitary sewer system. Solid wastes contaminated with blood or body fluids from high-risk patients are placed in sturdy, impervious bags before disposal.

Central Sterilization

The handling of contaminated instruments may present a serious hazard to personnel. Whenever possible, post-treatment and presterilization handling of contaminated instruments and materials must be carried out in an area separate from patient treatment areas. A central sterilization room (CSR) must be used if your DTF is equipped with one. CSRs provide the following benefits:

- Decreased risk of infection to dental staff and patients
- Efficient use of materials and personnel

The sterilization process in a CSR is broken down into three phases, each with distinct procedures, as indicated in table 11-1.

INFECTION CONTROL OVERSIGHT PROGRAM

Proper practice and monitoring of infection control is a command-wide responsibility. Because of the dynamics and volume of clinical activity, program management requires designated oversight, monitoring, and documentation.

Your DTF has appointed, in writing, an infection control officer. As a clinical supervisor, you will most likely assist this officer in program development and management. You may help:

- Develop a means of reporting, evaluating, and monitoring injuries and infections acquired by patients and staff

- Review and evaluate aseptic, isolation, and sanitation techniques used by the DTF
- Develop and present an orientation briefing on infection control policies, and infectious disease hazards in the DTF
- Ensure ongoing clinic staff training in infection control practices
- Document all committee or workshop meetings (conclusions, recommendations, actions, and followup monitoring)

Whatever your involvement in the DTF's infection control program, keep in mind its importance. Cross-contamination in the dental clinic can have serious and even fatal consequences.

OCCUPATIONAL HEALTH AND SAFETY PROGRAM

The goal of an Occupational Health and Safety Program is to provide a safe, healthful workplace, free from recognized hazards. A successful program accomplishes the following:

- Minimizes injuries and illnesses of personnel (staff, patients, and visitors)
- Protects equipment, material, and facilities from damage
- Promotes safe work habits to maximize productivity

Your occupational health and safety responsibilities are inherent in your role as a supervisor. You are accountable for your people. Your commitment to the activity's occupational health and safety program must be absolute and true.

Because of the complexity of this program, the following discussion only highlights program elements and reviews your responsibilities as a

Table 11-1.—CSR Sterilization Process

PRESTERILIZATION PROCESSING

1. INSTRUMENT CLEANING AND DECONTAMINATION
 - a. Packs broken down. Disposables placed in appropriate containers.
 - b. Manual scrubbing, ultrasonic cleaning, washer sterilizer processing (depending on facilities).
2. INSTRUMENT INSPECTION AND SORTING
 - a. Items inspected for wear, breakage, and cleanliness.
 - b. Items sorted according to sets or packs, as appropriate.
3. WRAPPING AND PACKAGING
 - a. Critical and semicritical instruments wrapped or packaged individually or in sets.
Exception: practical use of some semicritical items impaired by such action.
 - b. Sterilization indicators placed as required.
 - c. Packs labeled indicating sterilizer used, cycle or load number, pack expiration date.

TERMINAL STERILIZATION

1. STERILIZER LOADED
 - a. Packs loosely arranged in sterilizer chamber.
 - b. Initial sterilization log entries made.
 - c. Sterilization cycle parameters set, using manufacturer's instructions.

POST STERILIZATION PROCESSING

1. HANDLING AND STORING STERILIZED ITEMS
 - a. Packs allowed to cool before removal from sterilizer chamber.
 - b. Packs handled carefully and stored in well-ventilated area.
 - c. Final sterilization log entries made.

supervisor. Normally, each DTF has an appointed safety officer or safety manager. Consult this individual for answers to questions concerning your activity's occupational health and safety program. Table 11-2 lists the references recommended for a dental activity's safety reference library. You may find these references useful in the performance of your job and in the study for advancement.

PROGRAM ELEMENTS

The following elements are required in all Occupational Health and Safety Programs.

1. *Safety Management.* This area concerns the administration of the activity's program, including evaluation of program effectiveness; implementation and application of directives, regulations, and standards to activity conditions; management of funds related to the program; and coordination with occupational health, sanitation, security, and fire protection staffs on problems having safety implications.
2. *Accident Prevention and Hazard Control.* This area concerns the inspection of activity spaces, materials, and equipment to identify hazardous conditions, processes, and procedures.
3. *Safety Education, Training, and Promotion.* This area deals with practices and methods designed to instill safety consciousness in all personnel, both on and off the job.
4. *Accident/Incident Investigation Reports/Analyses.* There is an investigation report/analysis on any accident/incident.
5. *The Safety Officer.* This area concerns the staffing of the safety officer. Full-time safety managers or collateral duty safety officers are assigned, based on activity population (including patients and visitors).
6. *Safety and Occupational Health Training.* The primary concern in this area is the training of safety managers, safety officers, clerical assistants, and other personnel associated with program administration.
7. *Design, Operating Procedures, Purchasing Procedures, and Contract Reviews.* The concern here is the consideration of health and safety in the design, development, and engineering of facilities, equipment, systems, processes, methods, and operating procedures.

SUPERVISORY RESPONSIBILITIES

With regard to occupational health and safety, you, as the supervisor, must:

- Promptly respond to all reports of hazardous conditions within your work area.
- Promptly convey to the appropriate supervisor any report of a hazardous condition outside your work area.
- Personally investigate the location(s) where hazardous conditions are alleged to exist and prepare appropriate reports. Conduct your investigations when and where all alleged unsafe conditions exist (e.g., after dark, when surfaces are wet, or when weather is hot and humid).
- Initiate action to correct any health and safety deficiencies found. Use interim measures to reduce the probability and severity of injury/illness pending permanent correction.
- Notify the safety manager/officer, in writing, within 5 working days following the receipt of a hazardous condition report. In the notification, describe the condition and provide the date it was reported and the action taken.
- Encourage your personnel to promptly report unsafe and unhealthful conditions. Inform them that they have a right and obligation to do so. Assure them that they will not be subjected to any type of restraint, coercion, discrimination, or reprisal for their revelations.
- Continuously display within your DTF the procedures and instructions pertaining to hazardous condition reports and appeals. Ensure that hazard report forms are available. Locate them in a common area, i.e., an area available to all personnel.

DENTAL EQUIPMENT PREVENTIVE MAINTENANCE PROGRAM

An aggressive preventive maintenance (PM) program is the single most important factor in achieving maximum equipment performance,

Table 11-2.—Dental Activity Safety Reference Library

NUMBER	TITLE/SUBJECT
NAVMEDCOMINST 5100.1 series	Activity Safety and Occupational Health Program
BUMEDINST 6260.19 series	Mercury Control Safety Program for Dental Facilities
NAVMEDCOMINST 6260.7 series	Health Hazards of Beryllium in Dental Prosthetics Laboratories
SECNAVINST 5100.10 series	DON Safety and Occupational Health Policy
SECNAVINST 5100.15 series	Department of the Navy Awards for Achievement in Safety Ashore
OPNAVINST 5100.8 series	Navy Safety and Occupational Health Programs
OPNAVINST 5100.12 series	Navy Traffic Safety Program
OPNAVINST 5100.23 series	Navy Occupational Safety and Health (NAVOSH) Program Manual
OPNAVINST 5102.1 series	Mishap Investigation and Reporting
OPNAVINST 5103.1 series	Navy Hazardous Material Information System (HMIS)
OPNAVINST 11320.23 series	Authority and Responsibility for Fire Protection at Navy Shore Activity's
NAVFACINST 5100.14 series	NAVOSH Deficiency Abatement Program Ashore
29 C.F.R. 1910	General Industry Standards (OSHA)
29 C.F.R. 1960	Occupational Safety and Health Program for Federal Employees
Executive Order 12196	Occupational Safety and Health Programs for Federal Employees, dtd 26 Feb 80
NAVREGS 1973	Article 0702

NOTE: Small dental activities may not require the total library. Those within other activities normally consult the library of that activity.

efficiency, and usefulness. The formally refined preventive maintenance is the systematic care, service, and inspection for the purpose of sustaining equipment in a constantly serviceable condition (this includes detecting potential or minor faults and correcting them before they develop into a breakdown). PM programs provide regular and systematic equipment servicing and minor repairs. They also provide a means for early detection of potential equipment malfunctions, and to allow sufficient time to obtain replacement parts.

Your DTF's PM program is based upon these factors: the number of patients, the extent of dental services provided, the amount and type of equipment, and the availability of dental equipment repair technicians. Your activity type (shipboard, shore, mobile, etc.) also impacts on your PM program. For example, shipboard dental equipment is incorporated into the Ships' Maintenance and Material Management (3-M) System, so its scope is more comprehensive and detailed than a small branch clinic's program.

Following is a brief description of some of the more common elements of a PM program. Consult current local directives for further information on your DTF's PM program requirements. Refer to the Issue of *Ships' Maintenance and Material Management Manual*, OPNAVINST 4790.4 series, for more information on shipboard equipment PM.

OPERATIONAL MAINTENANCE

A major cause of equipment failure is improper use and care. Your DTF's PM program should address user PM, which is normally performed only on the outside of dental equipment. Operator PM consists of:

- Preoperation inspections for frayed electrical cords, cracked connections, broken glass, lack of lubrication, deteriorated rubber items, and the presence of accessories and supplies.
- During operation observations for any abnormalities such as erratic meter readings, unusual noises, odors, vibrations, or excessive heat.
- After operation procedures such as cleaning, checking fluid levels, compressed gas pressures, and electrical switches, and properly preparing the equipment for the next use or for storage.

MAINTENANCE VISITS

A dental equipment repair technician (DERT) conducts maintenance visits and maintenance inspections at your facility. Again, the frequency of these visits depends upon your PM schedule and the factors that influence it.

Prior to conducting a maintenance visit, the DERT contacts you and establishes a date and time. Convenience is considered but avoid extended postponement. The DERT reviews the appropriate references (including manufacturer's literature), determines the need for tools, test equipment, supplies, lubricants, and parts, and prepares and organizes administrative records for PM entries. To assist the DERT, be sure to communicate any equipment problems that you are aware of.

A maintenance visit will normally include:

- *Calibration.* Certain equipment items require calibration and adjustment to provide reliable diagnostic and therapeutic information.
- *Cleaning.* In areas not accessible to the user, cleaning can be of critical importance, particularly if moving parts are involved.
- *Checking for Electrical Leakage.* This check is made to ensure that there is no leakage beyond the limits of acceptable standards.
- *Lubrication.* The DERT lubricates the equipment according to manufacturer's instructions.
- *Inspection for Critical Safety Hazards.* Any items that present a potential hazard to the patient, operator, or the equipment must be withdrawn from use. The DERT tags these items as "Hazardous" and informs you that they are to be removed from service.
- *Operational Test.* The DERT checks all facets of equipment operation for acceptable performance (e.g., electrical grounding of equipment, adequacy of support for physically mounted items, accuracy of timing devices, and operation of safety valves).

MEDICAL/DENTAL MAINTENANCE WORK ORDER			
Date of request 4 September 1987		For additional information call: Ext: 2751 Name: DTCS FAY	
Requesting Activity Radiology Lab		PM no. 8736	PA or minor property no. PA 68442-10098
Location of equipment: Rm, Dept, etc. Room S2-23		Name of equipment to be repaired Intraoral X-ray	
Manufacturer GENDEX		Model no. CX 1000	Serial no. 420225
MIP no. (for ships)			
Description of work requested in your own words: Tubehead on newly installed unit drifts. Please correct.			
FOR SHOP USE ONLY			
Date parts: Ordered		Reqn or purchase order nos.	Work/job order no.
Received			
PARTS USED			
NSN or Mfg's part #	Nomenclature	Cost	Quantity
Manhours: BMET/DERT		Description of work performed/remarks:	
Date	HRS		
Total man hours			
Date job completed:			
Maint contract in effect			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
Warranty in effect			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
Work assigned to:		Note: This information is to be transferred to the NAVMED 6700/3 or the Automatic Data PM record.	
RECEIVED IN SHOP		OUT OF SHOP	
Signature:		Returned to Requesting activity:	
Date:		Date:	
		Signature:	

NAVMED 6700/4 (Rev. 7-81) 3/E 9105-LP-206-7020

Figure 11-4.—Medical/Dental Maintenance Work Order, NAVMED 6700/4.

The NAVMED 6700/3 is retained in the dental repair shop responsible for maintaining the equipment. When an item is transferred, this record is forwarded with the transfer documents.

The NAVMED 6700/4 is a tool used for DERT work control. It is used to develop a statistical data base on repair part cost and DERT utilization. It is used for corrective maintenance as well as PM, and provides input for the NAVMED 6700/3.

PRECIOUS METALS RECOVERY PROGRAM

The Precious Metals Recovery Program (PMRP) is a salvage program, for such metals as gold, silver, silver alloy, and platinum. The high cost of these metals demands recovery and reutilization, not only of the metals themselves, but also of precious metal-bearing materials, scrap, and residue.

As an advanced dental assistant and assistant administrator, you may be assigned as the DTF's PMRP coordinator and be required to:

- Monitor precious metals recovery functions within your DTF
- Request PMRP supplies from the Precious Metals Recovery Facility, Colts Neck, NJ
- Collect and account for all excess precious metals scrap and precious metal-bearing items
- Train personnel in recovery equipment operation, the techniques of recovery, and the handling of recovered precious metals
- Turn in precious metal-bearing items and scrap to the Defense Reutilization and Marketing Office (DRMO) (formerly DPDO) that services your DTF
- Maintain an audit trail of metals recovered and turned in (log books, receipts, shipping documents, etc.)
- Prepare required PMRP reports

PRECIOUS METALS RECOVERY IN THE DTF

At present, the most common ways to recover precious metals at DTF's are:

- Collecting scrap amalgam from dental operatories
- Collecting bench grindings from the dental prosthetic laboratory
- Recovering silver from x-ray fixing solutions
- Turning in exposed or outdated x-ray films

The frequency of these activities is determined by local schedules based on DTF workload. Scrap amalgam is normally collected in covered stainless steel containers located in the dental operator. These containers are emptied into a larger plastic container and appropriately packaged for shipment to the recovery facility. Laboratory grindings are placed in self-sealing plastic envelopes and turned in per local directives. A silver recovery

cartridge is used to recover silver from x-ray fixing solutions. The cartridge attaches to the x-ray developer, and the solutions are flushed through it. Silver-estimating test papers indicate when the canister is full. Once full, the cartridge is removed, replaced, and turned in to the appropriate office.

Do not underestimate the importance of the PMRP, its importance is stressed throughout the Department of Defense and its value is proven. You must provide proper security for recovered precious metals, recovery canisters, and metal-bearing items. Record recovery events accurately, and ensure retention of all documents concerning precious metals turn-in. And, finally, maintain close contact with your area's precious metals recovery representative to ensure efficient and effective program coordination.

QUALITY ASSURANCE PROGRAM

All DTF's, as part of their mission, must provide their patients the best possible care. This can be judged only if the quality of care rendered is measured against achievable standards. For this reason, the Naval Medical Department has established Quality Assurance (QA) Programs throughout, requiring a two-phase action: (1) evaluating the results of delivered care and (2) making improvements for increasing the quality of future care.

An effective QA program requires a continual review and evaluation that is problem-focused (i.e., it identifies a problem and works toward correcting it). DTF QA programs evaluate:

- Diagnostic and treatment procedures
- Patient satisfaction
- Quality, content, and completeness of dental record entries
- Unplanned hospitalizations
- Quality and appropriateness of emergency treatment
- Radiology and prosthetic laboratory quality control
- Appropriate use of antibiotics and other drugs
- Safety and sanitary provisions

- Communications within staff to improve patient care
- Professional practice in an ethical and legal manner
- Availability of dental care (including emergency and after hours care)
- Continuity of care
- Diagnosis and treatment consistency
- Infection control measures
- Effectiveness of the incident reporting system

- Followup action on identified problems. Although the dental record is the primary source for problem identification, there are other sources. Table 11-3 indicates some of these sources and the type of information derived from them. You can easily compare the items listed above to the source and information in the table.

Your involvement in your DTF's QA program can vary from facility to facility. The complexity and depth of the program depend largely on your DTF's size, patient load, clinical specialties, and the makeup of your patient population. The program's success, however, depends on total staff awareness and support. The motto for a successful QA program is: "Quality Assurance is Everyone's Business."

Table 11-3.—Problem Identification Sources in DTF's

<u>SOURCE</u>	<u>INFORMATION DERIVED</u>
Appointment Systems Appointment Logs	Timeliness of patient appointments; patient access and follow-up; patient referrals
Patient Surveys Patient Complaints	Patient satisfaction; staff attitude; patients' feeling toward quality of care; working time
Dental Records	Accuracy of entries; treatment compared to treatment plan; care provided; continuity of care
Peer Review	Correct care given, correct diagnosis, treatment techniques; patient instruction, appropriateness of treatment, technical performance
Infection Data Incident Reports	Complications, accidents, overdose, missed radiographic findings
X-ray Logs	Repeat radiographs, questionable equipment operative

For detailed information on your DTF's QA program, consult current local directives and *The Guide for Quality Assurance Programs for Naval Hospitals, Naval Medical Clinics, and Naval Dental Clinics*, NAVMEDCOMINST 6320.7 series and *Dental Quality Assurance/Risk Management (QA/RM) Program* NAVMEDCOMINST 6320.24 series.

One element of the QA program is the maintenance of a technical library. Most large DTF's have a sizable library, while other facilities may have only a few reference materials. In either case, you will most likely maintain the library, and you may be involved in the procurement of references.

TECHNICAL LIBRARY

Access to appropriate references is basic to the practice of dental care and necessary even for the leanest continuing education program. Lists of recommended books, journals, and publications have been a part of the Medical Department since the age of sail. Medical and dental personnel must have a basic set of publications to which they can refer.

A Library Committee, recommended under the QA program, may be established at your DTF. Its members evaluate the library's effectiveness and establish priorities in purchasing new library materials. If your DTF is small or isolated, you may not have a library committee. For this reason, the *Procurement of Professional Reference Materials and Publications*, BUMEDINST 6820.4 series, lists required and recommended references and gives procurement instructions. Refer to this directive when considering the purchase of technical library materials and publications.

PATIENT ADMINISTRATION

Patient administration, as discussed here, relates to the handling and processing of patients through your DTF. There are programs and systems to help ensure smooth patient flow and good customer relations. Some are local, but others are used Navy-wide and even throughout the Department of Defense. They all have the goal to meet the patient's needs in the best possible way.

This section covers dental sick call, the Defense Enrollment Eligibility Reporting System (DEERS), the Patient Contact Program, and the Fleet Liaison Program.

DENTAL SICK CALL

Dental sick call, is a designated time set aside to assess and treat patient needs. It includes not only emergency care but also dental examinations, overseas screenings, and dental consultations. In most cases, sick call is a patient's initial contact with your DTF. Much of your facility's credibility, public relations, and professionalism is gained or lost through the staff's performance at dental sick call.

As a senior dental technician, you may be directed to supervise certain areas of dental sick call. You must ensure that the technicians use sound judgment and maintain high professional standards when dealing with patients. Select personnel who exhibit a great deal of courtesy, respect, patience, empathy, and attention to detail.

Sick call also demands a good working knowledge of current directives, dental records, and organizational skills. You must impart this knowledge to your personnel and ensure that changes are incorporated smoothly and as soon as possible. An orderly, functional, and systematic sick call is essential to patient satisfaction and your DTF's entire operation.

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

The DEERS was developed following congressional initiatives that instructed the Department of Defense to devise a program for:

- Improving the control and distribution of military health care services
- Improving the ability to project and allocate health care program costs
- Minimizing the fraudulent receipt of health benefits through direct care and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (estimated at \$20 million and \$40 million, respectively)

The DEERS Program Office was established under the control of the Assistant Secretaries of Defense (Health Affairs and Manpower, Reserve Affairs, and Logistics).

Under the program, eligible beneficiaries must be enrolled in the DEERS in order to receive

medical and dental benefits. Dependents and retirees enroll by completing and submitting an Application for a Uniformed Services Identification and Privilege Card, (DD 1172). Active duty members are automatically enrolled by the Navy Finance Center.

Although you are not directly involved in the DEERS enrollment process, you are involved in verifying enrollment. In doing so, you determine whether a patient is eligible for routine dental treatment at your facility. Remember, you only verify eligibility. Establishment of eligibility is a function of the personnel officer or the personnel support activity (PSA).

DEERS Eligibility Checks

The DEERS and the identification (ID) card system are related. When an active duty member obtains new ID cards for their dependents, the information from the DD 1172 is entered into the DEERS data base. When a patient is without an ID card and does not appear in the DEERS data base, nonemergency care will be denied in all cases. Refer these patients to your department head or clinic director.

Perform a DEERS eligibility check on all nonactive duty patients presented to your DTF for treatment. The capabilities of your DTF will determine whether you may access the DEERS data base by telephone or through an on-line computer terminal. Once the check is performed, enter in the patient's dental record the date, eligibility status, and whether or not the patient is enrolled in the dental insurance plan. Dependents enrolled in the dental insurance plan are entitled only to treatment not covered under the plan. Patients requiring nonemergency treatment who are without a valid ID card but are in the DEERS data base will be provided treatment only after signing a statement that (1) indicates they are eligible, (2) that they understand that they must provide the ID within 30 calendar days (or be billed for the treatment rendered), and (3) gives the reason why they do not have a valid ID card with them.

A patient may be found ineligible for treatment based on DEERS checks for one or more of the following reasons:

- Sponsors are not enrolled in DEERS
- Dependents are not enrolled in DEERS
- Ineligible due to expired terminal eligibility date

- Sponsor is separated from active duty
- Spouse is divorced from sponsor and is not entitled to benefits as a former spouse
- Dependent child is married
- Dependent becomes an active duty member of a uniformed service (loses CHAMPUS benefits only). These patients will be denied routine nonemergency care by your department head or chair director. Instruct them to contact their sponsor's personnel office or the PSA to have the DEERS data base corrected or updated, as appropriate.

DEERS Eligibility Overrides

Although the DEERS and the ID card system are related, there are instances in which the patient may possess a valid ID card but does not show up in the DEERS data base, or shows up as ineligible. These patients may be provided dental treatment in the DEERS eligibility "overrides" listed below. Remember, in each of these cases, the patient must possess a valid ID card.

- Emergency Care - This is a medical decision and is determined by criteria established within your DTF.
- Dependents Recently Becoming Eligible for Benefits - Patients who become eligible for care in the previous 120 days may not show up on the DEERS data base. Verify this by checking the ID card date of issue.
- New ID Card - Patients presenting a new valid ID card issued within the past 120 days should not be denied care.
- Sponsors Entering Active Duty Status for More than 30 Days - A copy of the orders ordering a reservist to active duty for more than 30 days may be accepted for the first 120 days of the active duty period.
- Sponsor's Duty Station is Outside the 50 States or has an APO/FPO Address - Dependents in this situation should not be denied care as long as the sponsor is enrolled and in the DEERS and is eligible for treatment.

- Survivors - When a DEERS check indicates that a deceased sponsor is not enrolled, or that the survivor is listed as the sponsor, the survivor may be treated on the first visit. Refer the survivor to the appropriate personnel office for correction of the DEERS data base.

In most situations listed above, there are specific items required for verification. Before alarming the patient, be sure to check all current directives and memoranda.

DEERS is here to stay and is continually expanding to assist military treatment and services. By assuring that only eligible beneficiaries receive care, the DEERS benefits all.

PATIENT CONTACT PROGRAM

Navy health care professionals have long understood the need for good communications and rapport between patients and staff. The atmosphere of the DTF affects the patient's perception of the quality of care. Navy dental care is superb. Too frequently, however, contact points are not adequately trained in interpersonal relations. Many complaints would not occur if staff personnel presented a courteous, positive, and knowledgeable attitude that reflects genuine concern for the patient's welfare.

The Patient Contact Program was instituted to help alleviate these misperceptions. It is designed to enhance communication channels and provide a forum to receive and resolve patient complaints and problems quickly and efficiently.

Command Patient Contact Representative

As a senior dental technician, you may be assigned as the DTF's patient contact representative. As such you will:

- Serve as a liaison between the patients and the dental staff
- Be responsible for the DTF's Patient Contact Program
- Assist and direct other patient contact point representatives in serving the patient
- Receive and investigate patient complaints and ensure patient satisfaction whenever possible

- Maintain complete records of patient complaints
- Periodically assess patient satisfaction through analysis of complaints and patient surveys
- Identify high risk areas (i.e., those areas where complaints frequently occur) and take corrective action
- Keep higher command officials apprised as appropriate

Most DTFs have a fairly well-established Patient Contact Program. You are to maintain and improve its effectiveness. Stress the importance of the patient contact point representatives. Establish and maintain initial and followup training for your personnel. Whenever possible, do not assign personnel to contact points until they are appropriately trained. Handle patient complaints and contact point conflicts with an open mind and a great deal of tact and diplomacy. Try to minimize the potential for contact point conflicts. Ensure that the appearance of your personnel is professional and that the cleanliness and comfort of the DTF are maintained. Communicate with your patients through clear, readable signs and handouts. Mark support areas such as restrooms, telephones, information, and appointment areas. Ensure that patients are informed of unexpected delays, changes in policies or procedures, etc. And, finally, develop an understanding in your personnel of the patient's position. Eliminate stereotypic attitudes and ensure that patients are treated as they would like to be treated.

FLEET LIAISON PROGRAM

The Fleet Liaison Program, supports the Operating Forces. Experience during past hostilities and extended deployments has shown a considerable loss of man-hours due to emergency dental care. Such a record has led to the development of operational dental readiness standards. At present, minimum dental standards for unit readiness are 80 percent; i.e., 80 percent of a unit's personnel should be in dental classifications 1 and 2.

The goal of your DTF's Fleet Liaison Program is to attain and maintain the dental readiness standards for all supported units. Most programs do so through a recall system that: (1) helps identify treatment needs, (2) emphasizes preventive

measures to counter dental disease, and (3) initiates corrective dental treatment as required.

Large DTFs may have a fleet liaison department. Smaller DTFs will, at the very least, have a fleet liaison officer. You may be assigned to assist in fleet liaison functions by:

- Acting as a point of contact with units of the Operating Forces
- Coordinating the recall of and dental treatment services for serviced units
- Monitoring the dental operational readiness of serviced units
- Assisting in the preparation of required reports to your commanding officer and those of the fleet and shore activities serviced by your DTF
- Maintaining, when available, an accurate computer data base of the command's dental health status and treatment needs

Your DTF's Fleet Liaison Program has a definite impact on the overall readiness of Navy and Marine Corps personnel. Do not take your duties lightly, no matter how small your program may seem.

SUMMARY

The successful accomplishment of your activity's mission depends largely on how personnel and other resources are used. As a leading petty officer, you manage people and administer various programs within your DTF. Learn the basic principles of management, and learn all you can about the people and programs you will direct and coordinate. Be flexible in your efforts, but ensure that the command's goals are achieved and that the mission is brought to a successful conclusion.

REFERENCE LIST

- BUMEDINST 6700.36 series, *Medical and Dental Equipment Repair Manual*, June 1982
- BUMEDINST 6820.4 series, *Professional Reference Materials and Publications; Procurement of*, December 1978
- NAVMEDCOMINST 5100.1 series, *Activity Safety and Occupational Health Program*, February 1986
- NAVMEDCOMINST 6600.3 series, *Dental Infection Control Manual*, December 1986
- NAVMEDCOMINST 6150.1 series, *Health Care Treatment Records (NAVMED 6150/10-19)*, February 1987
- NAVMEDCOMINST 6320.7 series, *Quality Assurance Program for Naval Hospitals, Naval Medical Clinics, and Naval Dental Clinics*, September 1984
- NAVMEDCOMINST 6320.24 series, *Dental Quality Assurance/Risk Management (QA/RM) Program*, November 1987
- NAVMILPERSCOMINST 1616.1 series, *Navy Enlisted Performance Evaluation System*, May 1983
- OPNAVINST 1750.2 series, *Defense Enrollment Eligibility Reporting System*, July 1982
- SECNAVINST 6600.2 series, *Operational Dental Readiness Standards*, May 1984
- Dental Equipment Repair Technician*, NAVEDTRA 10680
- Navy Customer Service Manual*, NAVEDTRA 10119-B

CHAPTER 12

PERSONNEL RECORDS AND ACCOUNTING

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the contents of personnel service records.
2. Identify personnel manning documents and recognize their contents.

As a senior dental technician, you will often perform personnel liaison and support duties. Whether in a dental clinic administrative office or shipboard dental department, you will assist personnel on military career matters. Their service records are official histories of their careers. Although you will not normally prepare and maintain service records, you should be aware of their contents to help you perform your personnel support and manpower management duties.

This chapter covers officer and enlisted service records and personnel accounting documents. Such documents include the Enlisted Distribution Verification Report (EDVR), the Officer Distribution Control Report (ODCR), the Manpower Authorization, and the Manpower Change Request. For additional information on these subjects, refer to the *Naval Military Personnel Manual (MILPERSMAN)*, the *Navy Pay and Personnel Procedures Manual (PAYPERSMAN)*, and official Navy directives.

PERSONNEL SERVICE RECORD

Each person in the Navy has a service record. Established the day a member enters the Navy, it reflects the career history and is extremely important. It is an essential part of the Navy's personnel accounting and reporting system. It is also a ready reference file of documents used for proper personnel assignment and administration.

ENLISTED SERVICE RECORD

The Enlisted Service Record, NAVPERS 1070/600, is a folder containing official and unofficial personnel documents. The member's name,

social security number, and branch of service are located on the tab of the folder. The actual service record is kept on the right side of the folder, which is reserved for all official forms (pages 1 through 15). The left side is used for official and unofficial papers concerning the individual. Following is a description of the enlisted service record pages and their contents.

Right Side

Pages 1 through 15 are located on the right side of the service record. They generally have printed page numbers and are filed sequence, with page 1 on the bottom. The Serviceman's Group Life Insurance Election, VA Form 29-8286, and the Dependency Status Action, NAVCOMPT Form 3072, are exceptions. They are beneath page 2. **NOTE:** There are no pages 8 and 12.

PAGE 1, The Enlistment/Reenlistment Document—Armed Forces of the United States, DD Form 4, is prepared upon initial entrance into the service or for reenlistment following separation in excess of 24 hours. Page 1 is the basic document which establishes a legal relationship between the government and the enlisted member. It also specifies the exact terms of the agreement between the member and the U.S. Government.

Also considered **PAGE 1**, Immediate Reenlistment Contract, NAVPERS 1070/601, establishes a legal relationship between the government and the enlisted member who reenlists on board an activity within 24 hours of discharge.

PAGE 1A, Agreement to Extend Enlistment, NAVPERS 1070/621, is a legal agreement between the government and an enlisted member to extend the current enlistment for a specific period.

DEPENDENCY APPLICATION/RECORD OF EMERGENCY DATA

1. UNIT I.D. 33333		2. SHIP OR STATION USS YOSEMITE (AD-19)		3. <input checked="" type="checkbox"/> 4.	
5. NAME OF SPOUSE SUSAN ANN JOHNSON SMITH		6. DATE OF BIRTH OF SPOUSE 53FEB05		7. RELATIONSHIP WIFE	
8. PLACE OF MARRIAGE (CITY & STATE OR COUNTRY) NORFOLK, VA		9. DATE MARRIED 75JUN18		10. CITIZENSHIP OF SPOUSE US	
11. ADDRESS OF SPOUSE 123 MAIN ST., NORFOLK, VA 01234		12. DEP YES			
13. NAME OF CHILD OR DEPENDENT STEVEN NMN SMITH JR.		14. DATE OF BIRTH 76MAR26		15. RELATIONSHIP SON	
16. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)		17. DEP YES			
18. NAME OF CHILD OR DEPENDENT		19. DATE OF BIRTH		20. RELATIONSHIP	
21. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)		22. DEP			
23. NAME OF CHILD OR DEPENDENT		24. DATE OF BIRTH		25. RELATIONSHIP	
26. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)		27. DEP			
28. NAME OF CHILD OR DEPENDENT		29. DATE OF BIRTH		30. RELATIONSHIP	
31. ADDRESS (INCLUDE NAME OF CUSTODIAN IF OTHER THAN CLAIMANT)		32. DEP			
33. NAME OF FATHER JAMES ARTHUR SMITH, DECEASED		34. ADDRESS OF FATHER (SEE SPECIAL INSTRUCTIONS BEFORE COMPLETING BLOCK 35)			
35. DEP					
36. NAME OF MOTHER LYNDA MAY JONES SMITH		37. ADDRESS OF MOTHER (SEE SPECIAL INSTRUCTIONS BEFORE COMPLETING BLOCK 38) 123 MAIN ST., NORFOLK, VA 01234			
38. DEP YES					
39. WERE YOU PREVIOUSLY MARRIED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		40. PRIOR MARRIAGE DISSOLVED BY DEATH <input type="checkbox"/> ANNULMENT <input checked="" type="checkbox"/> DIVORCE		41. DATE 73DEC28	
42. PLACE, CITY & STATE OR COUNTRY PHILADELPHIA, PA					
43. WAS SPOUSE PREVIOUSLY MARRIED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		44. PRIOR MARRIAGE DISSOLVED BY DEATH <input type="checkbox"/> ANNULMENT <input type="checkbox"/> DIVORCE		45. DATE	
46. PLACE, CITY & STATE OR COUNTRY					
47. NAME		48. ADDRESS		49. RELATIONSHIP	
NEXT OF KIN (SPOUSE, NEXT OF KIN, NEAREST RELATIVE) LORI ANN MILLER		2610 MOORE AVE, CHARLESTON, WV		SISTER	
BENEFICIARY (PRINCIPAL, PAYEE & ALIEN) SUSAN ANN SMITH		123 MAIN ST, NORFOLK, VA 01234		WIFE 80	
DEPENDENT (SPOUSE, CHILD, NEXT OF KIN, NEAREST RELATIVE) SUSAN ANN SMITH		123 MAIN ST, NORFOLK, VA 01234		100	
DEPENDENT (SPOUSE, CHILD, NEXT OF KIN, NEAREST RELATIVE) LYNDA MAY SMITH		123 MAIN ST, NORFOLK, VA 01234		MOTHER 100	
INSURANCE (BRAND AND NAME) PRUDENTIAL LIFE INSURANCE CO.		BOX 500, LINWOOD, NJ 08221		444321	
13		3		76JUN28	
SMITH, STEVEN NMN		296-89-2055		X	

NAVPERS 1070/602 (REV. 1-75) (FORM 1070-602) (1-75)

Figure 12-1B.—Part 2, Part II, Dependency Application/Record of Emergency Data, NAVPERS 1070/602 (Front).

casualty reporting and notification of next of kin. Accuracy on this form is critical, because it is used to verify eligibility for dependents' benefits. Figures 12-1A and 12-1B display only the fronts of these forms.

Page 2 is an official document used by the Navy to determine persons to be notified in case of emergency or death; persons to receive death gratuity when no spouse or child exists; persons

to receive unpaid pay and allowances; persons to receive pay allotment if a member is missing or unable to transmit funds; commercial insurance companies to be notified in case of emergency; NSLI, SGLI, and VGLI in force.

Page 2 is prepared or updated when a change occurs in the name or address of a document or next of kin (other than dependent); name or address of a beneficiary, allottee, or insurer; spouse's

citizenship; religion; location of wills or other valuable documents; and any remarks on the reverse side of the form.

PAGE 3, Enlisted Classification Record, NAVPERS 1070/603, contains pertinent information on a member's aptitude test scores, civilian education and training, and personal interests. Any remarks or recommendations that may have significance on classifying and assigning the

member are also on page 3. The original is retained in the service record.

PAGE 4, Navy Occupation/Training and Awards History, NAVPERS 1070/604, contains a chronological record of the member's advancement, training and education, and awards received (figures 12-2A, 12-2B, and 12-2C).

PAGE 5, History of Assignments, NAVPERS 1070/605, provides a record of ships and stations

1. NAVY ENLISTED CLASSIFICATION RECORD				2. DESIGNATOR RECORD			
DATE	PRIMARY CODE	SECONDARY CODE	OFFICER'S INITIALS	DATE	DESIGNATOR	DUAL QUALIFICATION OR RELOCATION	TOFFICER'S INITIALS
16DEC83	DT-0000	0000	LBH				

3. RECORD OF NAVY SERVICE SCHOOLS ATTENDED (CLASS R, A, C, F, V AND E)					
COURSE TITLE AND SCHOOL LOCATION			COURSE TITLE AND SCHOOL LOCATION		
Dental Technician, Basic, Class, "A" School, NSDAT, NAVSTA, San Diego, CA					
EARNED NO.	COURSE LENGTH	DATE ENROLL	EARNED NO.	COURSE LENGTH	DATE ENROLL
DT-0000	12 wks	26SEP83			
DATE COMPLETED	FINAL MARK	CLASS STANDING	DATE COMPLETED	FINAL MARK	CLASS STANDING
16DEC83	SAT				
MANNER OF COMPLETION <input checked="" type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED FOR			MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED FOR		
SIGNATURE: L. B. HARRIS, LT, USN, PERS OFF			SIGNATURE:		
COURSE TITLE AND SCHOOL LOCATION			COURSE TITLE AND SCHOOL LOCATION		
EARNED NO.	COURSE LENGTH	DATE ENROLL	EARNED NO.	COURSE LENGTH	DATE ENROLL
DATE COMPLETED	FINAL MARK	CLASS STANDING	DATE COMPLETED	FINAL MARK	CLASS STANDING
MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED FOR			MANNER OF COMPLETION <input type="checkbox"/> GRADUATED <input type="checkbox"/> DROPPED FOR		
SIGNATURE:			SIGNATURE:		

4. TRAINING COURSES COMPLETED			5. EDUCATIONAL EXPERIENCE LEVEL		
DESCRIPTION OF COURSE DATE OR NAVPERS NUMBER	DATE COMPLETED	TOFFICER'S INITIALS	DESCRIPTION OF COURSE DATE OR NAVPERS NUMBER	DATE COMPLETED	TOFFICER'S INITIALS
EMR NAVEDTRA 10054-E1	31JAN84	LH			
M/R NAVEDTRA P03 10044	03JAN85	LH			
Dental Asst. Basic NAVEDTRA 10677-A1	03JAN85	LH			
Dental Asst. Adv. NAVEDTRA 10678	23NOV85	LH			
M/R P02 NAVEDTRA 10045	15DEC85	LH			

NAME OF MEMBER JONES, JOHN LEWIS	OFFICER'S INITIALS 000-00-0000	ARMY OR NAVY USN
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Figure 12-2A.—Page 4, Navy Occupation/Training and Awards History, NAVPERS 1070/604 (page 1).

6 PERSONNEL ADVANCEMENT REQUIREMENT			7 PERFORMANCE TESTS			8 ADVANCEMENT REDUCTION OR CHANGE IN RATING				
DESCRIPTION	DATE COMPLETED	OFF INIT	DESCRIPTION	DATE COMPLETED	OFF INIT	RATE ADVANCED REDUCED OR CHANGED	EFFECTIVE	TIME IN RATE COMPUTED FROM	OFF INIT	
DT3	03JAN85	LH	P03 M/L	01JAN85	LH	SA	01JUL83	01JUL83	LH	
DT2	03FEB86	LH	P02 M/L	10JAN85	LH	SA	DA	09SEP83	01JUL83	LH
						DA	DN	16FEB84	01FEB84	LH
						DN	DT3	16JUL85	01JUL85	LH
						DT3	DT2	16AUG86	01JUL86	LH

9 RECORD OF OFF DUTY EDUCATION AND VOC. TECH TRAINING									
DATE COMPLETED	NUMBER AND TITLE OF COURSE OR TEST	SCHOOL	GRADE	OFF INIT	DATE COMPLETED	NUMBER AND TITLE OF COURSE OR TEST	SCHOOL	GRADE	OFF INIT
31AUG84	HM 382 NAVEDTRA 10669-B		3.9	LH					
12JUL85	HM 1&C NAVEDTRA 10670-B		3.8	LH					
10MAY86	Introduction Psychology	Chapman College	B	LH					

10 GOOD CONDUCT AWARDS			11 DECORATIONS, UNIT AND MARKSMANSHIP AWARDS			
AWARD NUMBER	DATE EARNED	OFF INIT	AWARD	ACTIVITY	DATE OF AWARD	OFF INIT
			Navy Achievement	NDC, NAVSTA, San Diego, CA	13OCT85	LH

12 CAMPAIGN SERVICE AND OTHER AWARDS					
AWARD	ENGAGEMENTS	OFF INIT	AWARD	ENGAGEMENTS	OFF INIT

13 OTHER TRAINING COURSES/INSTRUCTIONS COMPLETED				
DATE COMPLETED	TYPE OF COURSE AND OR INSTRUCTION	DURATION	LOCATION	OFF INIT
08SEP83	Recruit Training	10 wks	RTC, NTC, Orlando, FL	LH
12MAY85	Preventive Dentistry	1 wk	NDC, NAVSTA, San Diego, CA	LH

Figure 12-2B.—Page 4, Navy Occupation/Training and Awards History, NAVPERS 1070/604 (page2).

where a member has been assigned. This page is used to record enlistments, extension(s) of enlistments, discharges, and sea and shore duty commencement dates. Whenever the service record is verified, a notation to that effect is made on page 5.

PAGE 6, Record of Unauthorized Absence, NAVPERS 1070/606, provides a record of all periods of unauthorized absence in excess of 24

hours, and lost time due to confinement by civil authorities or sick misconduct. Nonjudicial punishment (NJP) for these offenses is recorded on this form when punishment does not affect the member's pay. Unauthorized absences of 24 hours or less are recorded on page 13, Administrative Remarks.

PAGE 7, Court Memorandum, NAVPERS 1070/607, is used to record court-martial and NJP

PAGE 13, Administrative Remarks, NAVPERS 1070/613, provides a chronological record of significant miscellaneous entries not provided for elsewhere. It is also used to clarify entries on other pages of the service record. An example of page 13 is shown in figure 12-3.

PAGE 14, Record of Discharge from the U.S. Naval Reserve, NAVPERS 1070/615 (INACTIVE), is prepared upon honorable discharge by

reason of expiration of enlistment or expiration of obligated service. It is prepared for enlisted members on inactive duty only. The discharge of an enlisted member for any other reason is recorded on the Administrative Remarks, page 13.

PAGE 15, Certificate of Release or Discharge from Active Duty, DD Form 214, is prepared when a member is separated or discharged from active duty. This includes active duty for training

ADMINISTRATIVE REMARKS NAVPERS 1070/613 (REV. 10-81) S/N 0106-LF-010-8991		E-32
SHIP OR STATION USS YOSEMITE (AD-19)		
16 Jul 87:	Selectee for advancement to DT2 from participation in Cycle 99 of Navy-wide examination held in March 1987 and frocked to that rate per BUPERSINST 1430.16 series.	
	<p style="text-align: right;"><i>N. A. Johnson</i> N. A. JOHNSON, LT, USN, Personnel Officer By direction of CO</p>	
16 Jul 87:	I understand frocking is an administrative authorization to wear the uniform and insignia of a higher pay grade without pay entitlements or allowances of that grade. I further understand frocking is effected at my option, and any cost for additional uniforms or insignia will be defrayed by me and no retroactive pay, allowances, or reimbursements are authorized. I volunteer to be frocked to the rate of DT2.	
	<p style="text-align: right;"><i>Michael J. Downs</i> Michael J. DOWNS</p>	
WITNESSED:	<p style="text-align: right;"><i>N. A. Johnson</i> N. A. JOHNSON, LT, USN Personnel Officer</p>	
29 Jul 87:	<u>COMMANDING OFFICER'S NON-JUDICIAL PUNISHMENT</u>	
	DATE OF OFFENSE:	26 July 1987
	NATURE OF OFFENSE:	Violation of UCMJ Article 86, UA FM 05 July 1987 to 26 July 1987, 21 days UA, over liberty.
	DATE OF CAPTAIN'S MAST:	29 July 1987
	NON-JUDICIAL PUNISHMENT AWARDED:	Forfeiture of \$150.00 pay per month for two months, 30 days extra duty
	<p style="text-align: right;"><i>N. A. Johnson</i> N. A. JOHNSON, LT, USN, Personnel Officer By direction of CO</p>	
NAME		SSN
DOWNS, MICHAEL JOHN		012-34-5678
		BRANCH AND CLASS USN
		13 <input type="checkbox"/>

Figure 12-3.—Page 13, Administrative Remarks, NAVPERS 1070/613 (REV. 10-81).

of 90 days or more. The DD Form 214 provides a brief, clear-cut record of a period or term of active duty service with the Armed Forces. It provides the military a readily available source of information for determining enlistment eligibility. And it provides the service member a brief record of his or her active duty service, and it provides to government agencies an authoritative source of information to administer Federal and State laws. **NAVMILPERSCOMINST 1900.1** series provides complete instructions on the issuance of the DD 214.

Left Side

The left side of the enlisted service record contains official and unofficial papers concerning the member, which are required for record or safe-keeping purposes. They may include any of the following:

- Originals or copies of Standard Transfer Orders (STO), with copies of the endorsements and travel claims
- Discharge certificates
- *Statement of Service*
- Naval Correspondence Course completion letters
- Reports of examinations (other than medical)
- Service school certificates and diplomas
- Reports of Separation from Military Service
- Statement of Personal History, DD Form 389
- Documents pertaining to completion of security investigations
- Security clearances
- Birth certificates
- Marriage licenses
- Court decrees or court orders
- Correspondence pertaining to citizenship

- Special letters of commendation
- Record of Practical Factors (PARS)

When a member reenlists, a Career Performance Data Separator, NAVPERS 1070/617, is inserted on the left side of the service record. The following forms are filed beneath the separator:

- Certified copy of Enlisted Performance Record, NAVPERS 1070/609, from prior enlistment
- Reproduced copy of History of Assignments, NAVPERS 1070/605, from prior enlistment
- All performance evaluations and commendations from both prior and current enlistments.

All other official and unofficial documents are filed above the separator in chronological order, with the latest date on top.

OFFICER SERVICE RECORD

The NAVPERS 1070/66 is the file folder for the officer service record. The officer's name, SSN, and branch of service are located on the tab of the folder, just as on the enlisted folder.

The officer service record contains required official correspondence, and documents that reflect the chronological history of the officer's entire career. Although officers do not maintain their own records, they are ultimately responsible for ensuring that required information is placed and retained in their records at all times.

Following is a description of the documents contained in the officer service record. Not all service records will contain every document listed.

Right Side

The right side of the officer's service record is reserved for documents that affect the use and assignment of the officer concerned. The pages included on the right side, from top to bottom, are the following:

- Officer Qualification Questionnaire, NAVPERS 1210/5, outlines the officer's civilian and military experience. It also includes foreign language ability and educational achievements.

- Officer Biography Sheet, NAVPERS 5720/1, provides a brief biography of the officer's career: a chronological outline of all Armed Forces service, including enlisted service and reserve activity; Presidential and Navy Unit Citations; promotions with effective dates of rank; and authorizations of release for publicity purposes. All officers, Regular and Naval Reserve, on active duty are encouraged to complete the NAVPERS 5720/1. This sheet should be submitted periodically. Once submitted, the biography becomes the property of the Navy Department. Release of biographies to other than DOD authorized users requires written consent of the officer concerned.
- Training School Record, NAVPERS 318, maintained for officers commissioned prior to March 1965, provides a list of schools the officer attended, tests taken, and scores achieved.
- Annual Qualifications Questionnaire—Inactive Duty Reserve Officers, NAVPERS 1210/2, is used for promotion and disposition boards, mobilization assignment, and in the processing of personnel data for planning purposes. It is essential that the questionnaire be complete and accurate. The NAVPERS 1210/2 is distributed annually by 1 October to Naval Reserve Officers on inactive duty, excluding retired.
- Officer Preference and Personal Information Card, NAVPERS 1301/1, summarizes the officer's duties, advanced training, flight training, and marital status. It also provides a list of the officer's duty preference for the next assignment.
- Officer Data Card, NAVPERS 1301/51, is supplied by Naval Military Personnel Command (NAVMILPERSCOM). It contains the officer's educational background, promotion history, past duty assignments, and significant dates (birth date, pay entry base date, active duty base date, etc.). This card is forwarded by NAVMILPERSCOM, in duplicate, for verification by the officer concerned.
- Statement of Personal History, DD 398, or superseding Personnel Security Questionnaire (BI, SBI), DD Form 398, as appropriate. This questionnaire is used for background investigations and special background investigations.
- Permanent letters of designation or revocation of special qualifications, such as submarine qualification, surface warfare, Naval Flight Officer, and qualification for Command at Sea.
- Any other official correspondence affecting the use and assignment of an officer.

Left Side

The left side of the officer service record is reserved for official correspondence and documents of a permanent historical nature. Most of these documents relate to the officer's present tour of active duty. Documents on the left side that have no permanent effect on the officer's career or assignment are given to the officer upon transfer.

Documents on the left side, listed from top to bottom, include:

- Documents pertaining to personnel security investigations and certificates: Record Identifier for Personnel/Reliability Program, NAVPERS 5510/1, if appropriate; Personnel/Reliability Program Screening and Evaluation Record, NAVPERS 5510/3 Certificate of Personnel Security Clearance, OPNAV Form 5521/429, or superseding Certificate of Personnel Security Investigation, Clearance, and Access, OPNAV Form 5520/20, as appropriate; file copy of any pending National Agency Check Requests, DD Form 1584; or superseding Personnel Security Questionnaire (National Agency Check), DD Form 398-2, as appropriate; or request for Personnel Security Investigation, DD Form 1879 (upon receipt of requested investigation remove file copy and destroy)
- Leave Authorization (Officer and Enlisted), NAVCOMPT 3065. This form is used for granting regular leave and reporting data required for entries in pay records.

- Copy of Officer Appointment Acceptance and Oath of Office, NAVCRUIT 1000/20 (initial entry into service).
- Copy of Acceptance and Oath of Office, NAVPERS 1000/22, provides a record of sworn oath taken by the officer upon acceptance of current grade.
- Copy of Statement of Service, NAVPERS 1070/26, prepared by NAVMILPERS-COM for each officer. It indicates the pay entry base date (PEBD) and, when appropriate, the professional service date (PSD). The PSD is used in computing special pay for officers in the Medical and Dental Corps
- Signed copy of Dependency Application/Record of Emergency Data, NAVPERS 1070/602 (same as the Page 2 of enlisted service record).
- Copies of official correspondence originated at present command, and endorsements or copies of replies.
- Orders, with endorsements relating to the officer's tour at present command.
- Record of Code of Conduct training.
- Application for Armed Forces ID Card, NAVPERS 5512/1.
- Application for Uniformed Services Identification and Privilege card, DD Form 1172 (Dependent ID Card).
- Geneva Convention ID Card, DD Form 1934 (if appropriate). This application is used only for Medical Corps, Medical Service Corps, Nurse Corps, Dental Corps, and Chaplain officers. These ID cards are only issued when assigned onboard a ship or outside the United States.
- Request for a Certificate of Eligibility, DD Form 802, provides a record of the officer's request for a Federal Housing Administration (FHA) loan.
- Certificate of Termination, DD Form 803, provides a record of the officer's termination of an FHA loan.
- Insurance Applications provides a record of the status of an officer's insurance coverage (waiver actions, beneficiary changes, etc.)
- Copy of Navy Retired/Retainer Pay Data form, NAVCOMPT 2272
- Current photograph
- Officer's report of Home of Record and Place From Which Ordered to Tour of Active Duty, NAVPERS 1070/74.
- Copy of Certificate of Release or Discharge from Active Duty, DD Form 214, is issued upon discharge from the Navy.
- Miscellaneous documents pertaining to courses and schools completed, medals, awards, commendations, equator crossings, around the world cruises, etc., including Administrative Remarks, NAVPERS 1070/613.
- Temporary designation letters at present command (Command Security Manager, Top Secret Control Officer, Naval Courier, etc.).

PERSONNEL MANNING DOCUMENTS

Your CO is responsible for ensuring that your command's mission is accomplished successfully. As a senior dental technician, you may be required to supply the CO with information concerning personnel manning levels. To do this, you must ensure that the number of personnel assigned equals the amount of work required to accomplish the command's mission. You must also ensure that the personnel assigned are qualified to the job.

Three major documents will help you achieve this task:

- Enlisted Distribution Verification Report (EDVR)
- Officer Distribution Control Report (ODCR)
- Manpower Authorization (MPA)

ENLISTED DISTRIBUTION VERIFICATION REPORT (EDVR)

The EDVR is a monthly statement of your activity's personnel account. It lists all enlisted personnel assigned to your activity and provides:

- A summary of your activity's present and future manning status
- A statement of account for verification by your activity
- A permanent historical record at NAV-MILPERSCOM of your activity's enlisted personnel account
- A common reference point in any discussion of manning status between your activity and detailing/manning control activities

The EDVR must be verified monthly (upon receipt of the report). Verify all data listed in the "Verify Remarks" column of the report. Review the EDVR for new personnel and those deleted from the report. Verify changes to personnel data with your supporting personnel office. Submit corrections to the EDVR as specified in NAV-MILPERSCOMINST 1080.1 series.

Organization of the EDVR

The EDVR is organized into 11 sections and is distributed monthly by the Enlisted Personnel Management Center (EPMAC). Sections 1 through 3 contain data that requires special attention or action by your activity. They identify future personnel events.

Following is a brief description of each EDVR section:

SECTION 1, PROSPECTIVE GAINS.—

Personnel are listed in these categories:

1. Expired Prospective Gains—Members whose Estimated Date of Arrival (EDA) is prior to the current month. Members should have already reported. Listed by month in which they should report.
2. Current Prospective Gains—Members due to report on board your command during the current month.
3. Future Prospective Gains—Members due to report on board in future months. Listed

by month in which they are ordered to report.

SECTION 2, PROSPECTIVE LOSSES.—

Personnel are listed in these categories:

1. Expired Prospective Losses—Estimated Date of Loss (EDL) is prior to current month. Members should have already detached from your activity. Listed by month they should have detached.
2. Current Prospective Losses—Members under orders to transfer from your activity during the current month.
3. Future Prospective Losses—Members under orders to transfer from the activity within the next 10 months, listed by month in which they are to detach.
4. Expired Active Obligated Service (EAOS)—Members who should have already extended, reenlisted, separated, or transferred for separation, listed by month in which their EAOS expires.
5. Current EAOS—Members who must extend, reenlist, separate, or transfer for separation during the current month.
6. Future EAOS—Members who must extend, reenlist, separate, or transfer for separation within the next 10 months, listed by month that EAOS will expire.
7. EAOS (with extension) less than Projected Rotation Date (PRD)—Member whose EAOS is within 10 months, and the EAOS is less than the PRD.
8. Expired PRD—Members with a PRD prior to the current month who have not yet been ordered to detach.
9. Current PRD—Members with a PRD in the current month who have not yet been ordered to detach.
10. Future PRD—Members who are projected losses to the activity within the next 10 months, listed by the month of PRD.

SECTION 3, PERSONNEL ON BOARD FOR TEMPORARY DUTY, IN A DESERTER STATUS AND PERSONNEL ADMINISTRATIVELY DROPPED FROM NAVY STRENGTH ACCOUNTS.—This section lists members not appearing in sections 1 or 2, includes members on board the activity for temporary duty, members remaining on the activity account in a deserter status, or those who have been administratively dropped from Navy strength accounts.

Many activities use this list for career counseling purposes. Section 3 also lists alphabetically all members in your activity's personnel account, regardless of the status. This list is provided for internal use and should be used to verify the EDVR each month.

SECTION 4, TOTAL PERSONNEL ON BOARD IN DISTRIBUTION COMMUNITY SEQUENCE.—This section lists all enlisted personnel in the activity's personnel account except those in a deserter status and personnel who have been administratively dropped from Navy strength accounts. Personnel are listed by their Navy Enlisted Classification (NEC) and also alphabetically by rating and paygrade.

As well as Section 3, use Section 4 to verify the EDVR each month. To help in the verification process, you should post pen and ink changes as you become aware of them. Line through obsolete data, and write in new data directly above it. Then, when you receive the new EDVR, ensure that the changes have been incorporated.

SECTION 5, PERSONNEL STATUS SUMMARY.—This section is a numeric summary of your activity's personnel account. It shows billets authorized (BA), the Navy Manning Plan (NMP), and a summary of members on board and Projected on Board (POB). Stated simply, section 5 shows your activity's personnel strength, month by month, for the next 7 months.

SECTION 6, NAVY ENLISTED CLASSIFICATION (NEC) SUMMARY.—This section is a summary of Billets Authorized (BA) by NEC of members on board or expected to be on board.

SECTION 7, CNO BILLETS AUTHORIZED REVISION NUMBER XXXXX DATED YR/MO/DA.—This section summarizes CNO billet authorizations for your activity. It allows you to relate your activity's manpower authorization to actual personnel on board.

SECTION 8, NEC BILLET/PERSONNEL INVENTORY.—This section lists NEC by rating for which your activity has billets authorized. It reflects personnel totals from the current month through 7 months in the future.

SECTION 9, NEC MANAGEMENT SECTION.—This section provides a list of personnel qualified in more than two NECs.

SECTION 10, OFF/ENL DIARY MESSAGE SUMMARY (EPMAC Report 0980).—This report is included with the EDVR each month for every Unit Identification Code (UIC) in an active status. It is a record of changes affecting your activity, reported by your supporting Personnel Support Detachment. Changes received after the monthly cut off date will appear on the next summary.

SECTION 11, DUTY PREFERENCE LISTING.—This section reflects the encoded duty preferences submitted by your activity's personnel within the past 2 or 3 months. It is strictly used to verify that the preferences shown are those submitted by the members.

OFFICER DISTRIBUTION CONTROL REPORT

The ODCR is prepared monthly by the Commander, Naval Military Personnel Command (COMNAVMILPERSCOM), for each activity with officer billet authorizations. It provides your activity with a routine system to verify information contained in the NAVMILPERSCOM officer personnel data bank, and provides COMNAVMILPERSCOM with information needed to determine and evaluate officer billet requirements of each activity. The ODCR reflects the following:

- Activity identification data and related items
- Billets authorized and related items
- Individual officer personnel data

Change to activity name, billets authorized, or Manpower Requirements Plan (MARF) codes.

Verify the ODCR upon receipt and ensure that changes and corrections are completed as described in NAVMILPERSCOMINST 1301.2 series. Error codes may be printed on the report to help locate incorrect information. They do not, however, cover all possible errors, so verify the ODCR carefully.

MANPOWER AUTHORIZATIONS

The CNO allocates military personnel to each activity by publishing the *Manpower Authorization (MPA)*, OPNAV Form 1000/2. The MPA lists the number and types of billets authorized

for your command. For officers, it provides billet title descriptions, Navy Officer Billet Classification Codes (NOBCs), and grades. For enlisted personnel it provides rates (rating and paygrade), with NECs added when needed to identify billet requirements.

The MPA is an integral part of the Navy Manpower and Personnel Management Information System (MAPMIS) and is used for the following:

- By the Chief of Naval Personnel and the applicable enlisted personnel distribution office to show your activity's manpower needs. It also provides required personnel distribution and Naval Reserve recall requirements.
- It is the single official statement of organizational manning and billets authorized. These are the billets approved by the CNO for current and possible future operating condition.

Manning documents are issued for guidance. Commanding officers are responsible for ensuring that their MPAs reflect the minimum quantity and quality (including skills, paygrades, and special qualification) of billets needed to support the command's mission, tasks, and functions. Review your activity's MPA periodically to help identify any areas where you can save manpower or reduce skill levels without adversely affecting command mission. Changes to the MPA are requested by your commanding officer as prescribed in OPNAVINST 1000.16 series. The Manpower Authorization Change Request, OPNAV Form 1000/4A, is normally used for this purpose.

Using Information from the Manpower Authorization

When used in conjunction with your activity's organization manual, the MPA provides information about each military position. It also provides the number and types of persons available to fill each position.

A useful personnel management tool can be developed by transferring billet information from the MPA to an organization chart of your activity. Include the number of personnel by paygrade, Navy Officer Billet Codes (NOBCs), and NECs.

You can further identify each billet by placing a piece of clear plastic over the chart and, use a grease pencil to enter the name of the individual filling each billet. This chart is useful in obtaining information for personnel reports and for local personnel management.

SUMMARY

The service record is the official history of an individual's naval career, and matters pertaining to it require your utmost attention and knowledge. As a senior dental assistant you are not responsible for maintaining personnel service records. But you must know the contents to perform your personnel liaison and support duties.

With the proper use of personnel accounting reports such as the EDVR, ODCR, and the MPA, you can keep track of your activity's manning levels. These documents allow your command to function effectively and efficiently. And, you will be aware of all personnel changes and be able to plan accordingly.

REFERENCES

- Naval Military Personnel Manual*, Articles 5030160, and 5030200 through 5030445
- OPNAVINST 1000.16 series, *Manual of Navy Total Force Manpower*, August 1986
- NAVMILPERSCOMINST 1080.1 series, *Format and Procedures for Validation of Enlisted Distribution and Verification Report (EDVR)*, April 1986
- NAVMILPERSCOMINST 1301.2 series, *Officer Distribution Control Report*, NAVPERS 1301/5 (REV. 10-80); format and procedures for validation of, May 1981
- NAVMILPERSCOMINST 1616.1 series, *The Navy Enlisted Performance System Manual*, May 1983
- NAVMILPERSCOMINST 1900.1 series, *Certificate of Release or Discharge from Active Duty*, DD Form 214, September 1986

CHAPTER 13

DENTAL SUPPLY

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify elements of the Federal Supply Catalog System.
2. Identify material computing requirements.
3. Identify methods for procuring dental supplies.
4. Identify forms related to receiving, issuing, and transferring dental supplies.
5. Identify inventory control procedures.
6. Identify supply items requiring special storage, security, and safety procedures.

The supplies maintained at your dental treatment facility will determine the ultimate effectiveness of its mission. As an advanced dental assistant, you may be assigned to a supply department at a large DTF, or you may even maintain your own dental supply department at a smaller DTF. This chapter gives an overview of the Navy's Supply System and how it relates to a dental supply department.

MATERIAL IDENTIFICATION

There are over 4 million supply items in the Department of Defense Supply System. The Navy Supply System alone stocks over 1 million items. Each item must be cataloged, procured, and accounted for. This would be an impossible task if we relied entirely on the names and descriptions of the items.

A material identification system provides a means of identifying a specific item, without the need for name or item description. An example would be the identification numbers for items in a mail order catalog.

The Federal Catalog System was developed by the Federal Government as its means for material identification.

FEDERAL CATALOG SYSTEM

The Federal Catalog System lists all supply items carried in the Federal Supply System. The catalog system names, describes, classifies, and numbers all items carried under centralized inventory control by the Department of Defense and the civil agencies of the Federal Government. It is also used by the North Atlantic Treaty Organization (NATO) countries. Only one identification number is used for a supply item. Each supply item is listed by National Stock Number (NSN).

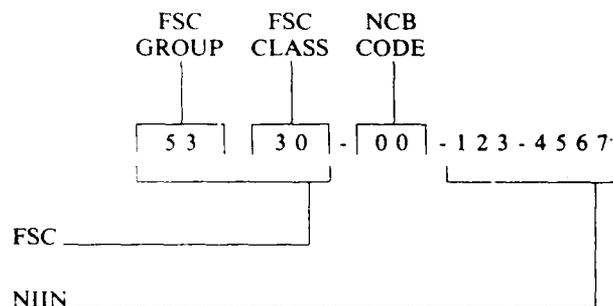
The Federal Catalog System is administered by the Defense Logistics Agency (DLA), under the general direction of the Assistant Secretary of Defense (Installations and Logistics).

National Stock Numbers

A 13-digit National Stock Number (NSN) is used in the management of all supply ordering, receiving, issuing, etc., and in supply publications where the item is referenced. The first four digits are the Federal Supply Classification (FSC) number; the last nine digits are the National Item Identification Number (NIIN).

The first two digits of the NIIN are the National Codification Bureau (NCB) code, which identifies the country that assigned the NSN.

These codes are listed in Chapter 2 of **NAVSUP P-485**. The remaining seven digits of the NIIN are used to identify all NSN items contained in the Federal Supply Classification System.



Federal Supply Classification System

When you work in a supply department, you will become familiar with many different supply sources, but the Federal Supply Classification (FSC) System is the most common source used throughout the Navy.

The FSC system classifies all supply items used by the Federal Government. There is only one, four-digit FSC class for each supply item. The first two digits indicate the group or major division within a group; the last two digits identify the FSC class within the group. There are 76 assigned groups (e.g., 65 is the group number for medical, dental, and veterinary equipment and supplies). These groups are listed in the *Afloat Supply Procedures Manual*, **NAVSUP P-485**.

IDENTIFICATION LIST (IL).—An IL is published on microfiche by the Defense Logistics Service Center (DLSC). It provides information relating to acquisition advice codes, units of issue, NSNs, index numbers, and a brief description of each item listed. It also contains illustrations of selected items.

MANAGEMENT DATA LIST (MDL).—The MDL lists all supplies carried in the Federal Catalog System. It is published in microfiche form and provides:

- Action codes (identify actions not previously published)
- Acquisition Advice codes (indicate the method of procurement)
- NSN

- Unit price of each item of issue
- Packaging information
- Weight and cubage data (provided for logistical planning purposes)

The MDL will assist you in identifying supplies currently stocked in the system, those that have been deleted, and necessary cost data.

MEDICAL CATALOG.—The medical catalog, developed by the FSC system, lists only the medical and dental supplies and equipment maintained in the FSC system. You must become familiar with this catalog, because its descriptions, illustrations, and management and reference data will help you to identify and select items used to support the medical and dental communities. Published and distributed on microfiche, the catalog has three volumes:

- Volume I - Introduction
 - FSCM Index - Federal Supply Codes of Manufacturers
 - NSN Index - NSNs in numerical sequence
 - Colloquial Index (Glossary)
 - Approved Item Name Index
 - Illustrative/Identification Data
 - Requisition/Storage/Management Data
- Volume II - Components of sets, kits, and outfits
- Volume III - Master Cross Reference List (MCRL)
 - Part 1 - reference number to NSN (manufacturer's part number to NSN)
 - Part 2 - NSN to reference number (NSN to manufacturer's part number)
 - Part 3 - FSCM to reference

The microfiche identifies the volume. Its heading (readable without magnification) gives the catalog title, volume number, "as of" date, first data entry on each fiche, publication effective date, and the sequential fiche number.

Medical catalogs are provided through an automatic distribution list. If your dental facility

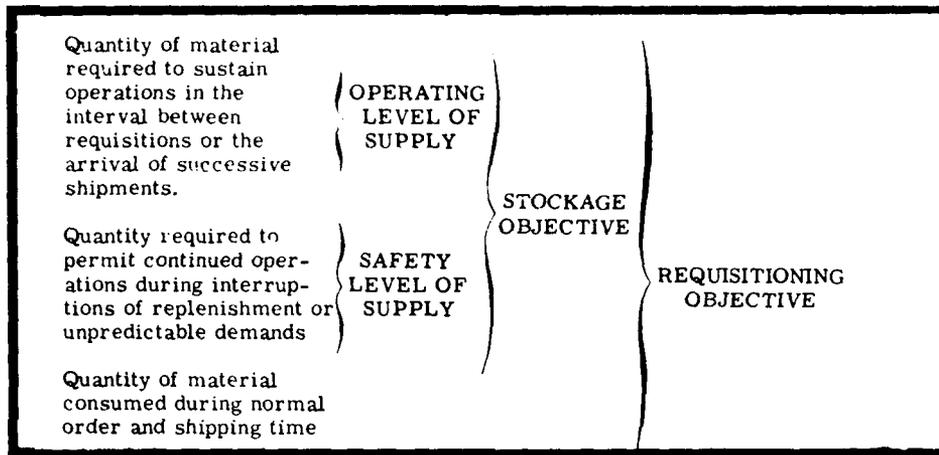


Figure 13-1.—Levels of supply.

is not on the distribution list, you may request a copy by forwarding a letter to: Commanding Officer, Navy Fleet Material Support Office, P.O. Box 2010, Mechanicsburg, PA 17055-0787.

NAVY ITEM CONTROL NUMBER (NICN)

Items with NICNs are not included in the Federal Catalog System, but are stocked or monitored by the Navy Supply System. An NICN is a 13-character item identification number assigned by Inventory Control Points (ICPs) or other Navy Item managers for permanent or temporary control of selected non-NSN items. The first four positions of the NICN are numbers followed by a two-position alpha code that identifies the NICN. The remaining seven characters may be numbers or a combination of alphanumeric codes, which in conjunction with the NICN code uniquely identify each NICN.

EXAMPLE: 7520-LF-000-1234

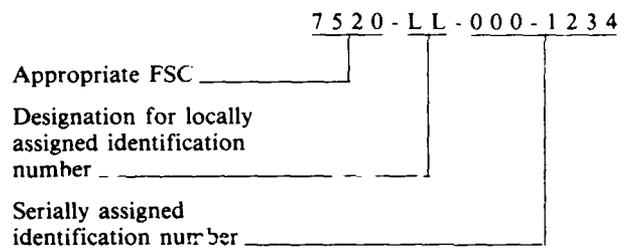
Current NICN codes are listed in Chapter 2 of NAVSUP P-485. For dental supplies you will normally use the following NICN codes:

- LF when ordering forms
- LP when ordering publications

LOCAL ITEM CONTROL NUMBER (LICN)

If you are attached to a ship, you may use LICNs (formally called Local Stock Numbers). LICNs are for local use only. These numbers may be assigned to shipboard stocked consumables not identified by an NSN, a NATO stock number, or an NICN. They distinguish between the NICNs

that are authorized in supply transaction documents and those that are not. An LICN contains 13 characters: the first four are a numeric code that corresponds to the FSC of similar NSN items; the fifth and sixth characters are always "LL"; and the remaining seven digits are the serially assigned identification numbers:



LEVELS OF SUPPLY

All dental facilities must control their supply quantities to avoid shortages of some items and oversupply of others. So there are rules that govern the levels of supply; these rules indicate the quantities of stock that should be maintained by a facility.

SUPPLY LEVEL TERMINOLOGY

Levels of supply are expressed in two ways: in terms of the number of units of an item or in terms of months of supply. Months of supply is the most commonly used method and is best for items that are in recurring demand.

Figure 13-1 illustrates the relationship between the various levels of supply. Four different measurements are used to express supply levels:

- *Operating Level.* This measurement indicates the quantity of an item required to

sustain operations at a facility during the interval between requisition or between the receipt of successive shipments of supplies. This measurement should be based upon the length of the replenishment cycle. For example, if requisitions are submitted once every 2 months, the operating level of supply would be the quantity of the item that is consumed every 2 months. This level will vary with different items.

- **Safety Level.** This measurement indicates the quantity of an item to be maintained over and above the operating level. This level ensures that operations will continue if replenishment supplies are received late, or if there is an unpredictably heavy demand for supplies. This measurement simply provides a margin of safety.
- **Stockage Objective.** This measurement indicates the maximum quantity of an item required to support operations at a facility. This is the sum of the *operating level* and the *safety level*. For example, if the operating level of an item is 80 units and the safety level is 20 units, you should maintain 100 units of that item at all times to meet the stockage objective.
- **Requisitioning Objective.** This measurement indicates the maximum quantity of an item that should be kept on hand and on order to support the operations of a facility. This is the sum of the *operating level*, *safety level*, and *the quantity of an item that will be consumed during the period between submission of the requisition and the arrival of the shipment*.

COMPUTING REQUIREMENTS

To determine the levels of supply you must maintain, you may be required to compute and record usage data for medical and dental materials. Up-to-date stock record cards (discussed later) will help you to determine material usage rates. You will need this usage data when you prepare requisitions that require justification based on past performance.

Usage Rates

Average monthly usage rates are based on the quantities of stock items issued during the 12

months of usage and the number of dental officers at the facility during that period. The monthly usage rate of an item indicates the quantity of the item needed to support one dental officer for one month. For example, a dental facility issued 144 units of an item during a 12 month period. The facility has an average of four dental officers attached during that period. The monthly usage rate would be three units, computed as follows:

$$\frac{\text{Total issues of an item during past 12 months}}{12} \times \frac{1}{\text{Average number of officers assigned during past 12 months}} = \text{USAGE RATE}$$

OR:

$$\frac{144}{12} \times \frac{1}{4} = \frac{144}{48} = 3 \text{ Units}$$

To determine future supply requirements, you must consider anticipated changes in the number of dental officers attached to your facility.

Authorized Dental Allowance Lists

Authorized Dental Allowance Lists (ADALs) list equipment, supplies, and consumables to be maintained for both Afloat Units and Fleet Marine Force (FMF) Units. When attached to either of these units, you will be required to maintain all items listed on the applicable ADAL.

ADALs are developed, maintained, and distributed by the Naval Medical Material Support Command (NAVMEDMATSUPPCOM). Changes are published in the *Navy Medical and Dental Material Bulletin*. ADALs are scheduled for republication at least every 2 years, or when significant changes occur.

AFLOAT UNIT ADALs.—These ADALs list equipment, supplies, and the minimum quantity of consumables required to be maintained on board at all times. The ship's type/class and dental mission determine the items contained on the ADAL.

FLEET MARINE FORCE (FMF) ADALs.—FMF ADALs provide a list of medical/dental equipment and supplies needed to perform the health care mission throughout the Marine

Amphibious Force (MAF). An FMF ADAL is designed to support a specific number of patients. The MAF authorized allowance list is determined by using the worst case scenario of 20,000 casualties in a 60-day period.

FMF health care requirements are influenced by the following:

- Fluctuations in combat intensity and the associated casualty rates
- Evacuation policies/capabilities
- Health care support available

Because of this, revised ADALs are designed to improve initial and subsequent arrival of supplies and equipment into combat zone.

FMF units requisition all dental material from the Medical Logistics Company. These materials may be line items for replacement, or complete allowances for initial outfitting.

FMF ADALs are packaged and stored in modules. These modules form an ADAL into a functional unit designed to establish a specific health care capability or to treat a predetermined number of patients.

PROCUREMENT

Working in a supply department, you may be required to prepare procurement documents. Procurement is the act of obtaining supplies or services. To order supplies you must first compute the required quantities as explained above.

Supplies are ordered from many different sources. This section provides information on those sources and on the procurement documents used. It also explains the regulations you must follow when ordering supplies.

FEDERAL ACQUISITION REGULATIONS (FARs)

FARs are the primary regulations used by all Federal Executive Agencies in the procurement of supplies and services. It provides coordination, simplicity, and uniformity in the federal acquisition process. The FAR lists required sources of supply by priority as described below:

1. Agency Inventories: e.g., items listed in the *Navy Medical and Dental Material Bulletin* and items in excess at your command. These items are free of charge.

2. Excess, Defense Reutilization Marketing Office (DRMO)/Disposal (formerly DPDO). These items have been surveyed at other commands and turned in for disposal. They may range from brand new to unusable. These items are normally free of charge.

- *3. Federal Prison Industries (Unicor/FPI). These items are manufactured by inmates of federal prisons and sold to all government agencies.

- *4. Institute for the Blind/Handicapped. These items, manufactured by individuals who are blind or handicapped, are sold to all government agencies.

5. Standard Stock. General Services Administration (GSA), Defense Logistics Agency (DLA), and Military Inventory Control Points (ICPs) provide the Navy Supply System with a variety of supplies (e.g., GSA provides administrative supplies, DLA provides medical and dental supplies). This is the Navy's most common source of supply.

6. Federal Supply Schedules (VA, GSA contracts). Although these items are contracted for the government, they are non-NSN.

7. Open Market. A purchase order is required. This source is used only when items are not available through government sources.

SUPPLY DOCUMENTS

As an advanced dental assistant, you may be required to identify and prepare documents used when requisitioning supplies and services from the sources listed above. The preparation and use of these documents is explained below.

MILSTRIP Requisition

The Military Standard Requisitioning and Issue Procedures (MILSTRIP) provides a common language for supplying materials to the Army, Navy, Air Force, Marine Corps, and General Services Administration (GSA). They also provide requisition documents that can be processed both manually and electronically. These documents

* Many products available from Federal Prison Industries and the Institute for the Blind/Handicapped have NSNs. This allows direct ordering through the Navy Supply System.

DOC IDENT	QUANTITY	STOCK NUMBER	ADD	ISSUE	QUANTITY	DOCUMENT NUMBER	SERIAL	SUPPLEMENTARY ADDRESS	FUND	SYSTEM	PROJECT	PROG	REQ. DATE	ADV	STAT														
SEND TO:															REQUISITION IS FROM:														
N0244 NSC SAN DIEGO, CA															N66022 NDC SAN DIEGO, CA														
EDITING DATA															STOCK NUMBER														
DOC IDENT															STOCK NUMBER														
A 0 1 N D Z T															6 5 2 0 0 0 1 2 3 4 5 6 7														
DOCUMENT NUMBER															REMARKS														
N 6 6 0 2 2 7 1 5 5 0 0 0 1															Used when exception data is pertinent to processing the requisition.														
FUND															STATUS DATA														
2 S 9 L R P 5 1 5															0 7 0 8 0 9														
ADVISE																													
2 J																													
DOC IDENT															QUANTITY														
STOCK NUMBER															DOCUMENT NUMBER														
ADD															SERIAL														
ISSUE															SUPPLEMENTARY ADDRESS														
QUANTITY															FUND														
SYSTEM															PROJECT														
PROG															REQ. DATE														
ADV															STAT														

Figure 13-2.—DOD Single Line Item Requisition System Document (Manual) (DD Form 1348).

contain all the information necessary to order, issue, ship, and account for the requested material.

MILSTRIP requisitions are used to requisition standard stock items. They are prepared on the DD Form 1348 or on a standard naval message. Additional information on **MILSTRIP** requisitioning can be found in the *MILSTRIP/MILSTRAP Manual, NAVSUP P-437*, or the *MILSTRIP/MILSTRAP Desk Guide, NAVSUP P-409*.

DOD Single Line Item Requisition System Document (Manual), DD Form 1348, is used to manually order standard stock items. As shown in figure 13-2, it contains data blocks A, B, and C, and card columns (cc) 1 through 69. The following block-by-block descriptions explain how this document is prepared:

Block A (SEND TO:) - Enter the service code and UIC, name and location where the requisition is going.

Block B (REQUISITION IS FROM:) - Enter the service code, UIC, name and address of the requisitioner.

Block C - Requisitioner either leaves this block blank or enters the noun name of the requisitioned item.

Document Identifier (1-3) - This is a three-position code that indicates the purpose and use of the document (e.g., requisition, referral,

followup, status). Examples of codes you may use are:

- AO1, for overseas shipment of items with NSN or NATO stock numbers
- AOA, for domestic (CONUS) shipment of items with NSN or NATO stock numbers

Routing Identifier (cc 4-6) - This is a three-position code used to identify the supply source (where the requisition is being sent). Examples:

- NBZ - Naval Supply Center (NSC) Jacksonville
- NDZ - NSC San Diego

Media and Status Code (cc 7) - This code indicates the type of status required, the activity to receive the status, and the means of transmission. Example:

- T - 100 percent supply and shipment status to requisitioner in cc 30-35

Stock Number (cc 8-22) - This is the 13-digit National Stock Number (NSN) of the item being ordered.

Quantity (cc 25-29) - This is a five-digit number for the quantity being ordered. Example:

- 00001 through 99999

Document Number (cc 30-43) - This code has four basic elements:

cc 30 - Requisitioner's service code. Examples of Navy codes include:

- R - Pacific Fleet Operating Units
- V - Atlantic Fleet Operating Units
- N - Ashore Activities

cc 31-35 - UIC of the requisitioner
 cc 36-39 - Julian date. Figures 13-3A and 13-3B show the Julian calendar for a regular calendar year and a leap year

cc 40-43 - The locally assigned serial number, never duplicated on the same day

JULIAN DATE CALENDAR

(PERPETUAL)

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

NAVSANDA FORM 1176-1 (1-65)

FOR LEAP YEAR USE REVERSE SIDE

STOCK NO. 0100-503-5260

D-251131

Figure 13-3A — Julian Date Calendar (Perpetual), NAVSANDA 1176-1, front.

JULIAN DATE CALENDAR

FOR LEAP YEARS ONLY

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

NAVSANDA FORM 1176-1 (1-65)

(USE IN 1968, 1972, 1976, etc.)

STOCK NO. 0108-503-5260

D-25028

Figure 13-3B.—Julian Date Calendar (For Leap Years Only), NAVSANDA 1176-1, reverse.

Urgency of need Designators				
Force/ Activity Designators		Unable to Perform Mission A	Impaired Operational Capability B	Routine C
I	In Combat	1	4	11
II	Positioned for Combat	2	5	12
III	Positioned to Deploy/ Combat	3	6	13
IV	Other Activity & Selected Reserve Forces	7	9	14
V	All Other	8	10	15

Figure 13-4.—Urgency of Need Designator.

Demand Code (cc 44) - The demand code is entered by the requisitioner. Enter "R" for items with a recurring demand and "N" for items with a nonrecurring demand (one-time use).

Supplementary Address (cc 45-50) - This code may be used by the requisitioner to identify another activity that is to receive the status or billing. Enter that activity's service code in cc 45 and its UIC in cc 46-50.

Signal Code (cc 51) - The signal code is mandatory. It serves a dual purpose: it identifies the activity to receive the material and the activity to receive the billing.

Fund Code (cc 52-53) - Fund codes are used to properly bill an activity for the material received. This code is assigned by the Authorized Accounting Activity.

Distribution Code (cc 54-56) - Distribution codes serve a dual purpose on Navy requisitions: cc 54 may indicate a monitoring activity, and cc

55-56 must indicate the Cognizance Symbol. The cognizance symbol, one number and one letter (e.g., 9L is used for medical/dental supplies), is used to provide supply management data. The number indicates the stores account where material is maintained in the supply system.

Project Code (cc 57-59) - This is a mandatory entry for Navy activities. This code helps a supplier determine the appropriate method of handling and marking a shipment.

Priority (cc 60-61) - The priority designator is determined by the assigned Force/Activity Designator (F/AD) and the appropriate Urgency of Need Designator (UND) as shown in figure 13-4.

Required Delivery Date (cc 62-64) - The Required Delivery Date (RDD) is the date the material must be delivered to the requisitioner.

Advice Code (cc 65-66) - A requisition normally requires no advice code entry. It is used only to indicate special conditions, circumstances, or restrictions that apply to items ordered.

JOINT MESSAGEFORM							SECURITY CLASSIFICATION			
PAGE	DTG/RELEASER TIME			PRECEDENCE		CLASS	SPECAT	LMF	CIC	ORIG/MSG IDENT
	DATE TIME	MONTH	YR	ACT	INFO					
OF										
BOOK	MESSAGE HANDLING INSTRUCTIONS									
<p>FROM: USS JOHN PAUL JONES DD-932</p> <p>TO: NSC NORFOLK VA</p> <p>UNCLAS E F T O</p> <p>MILSTRIP REQN</p> <p>1. ADA/NNM/0/6520001234567/EA/00006/V52192/9277/0001/R/Y00171/A3E/ BLNK/9L/RP5/15/BLNK/2J.</p> <p>(The NTP 3 contains detailed procedures for completing the remainder of this Naval Message)</p>										
6 5 4 3 2 1 0	DISTR									
DRAFTER TYPED NAME TITLE OFFICE SYMBOL PHONE						SPECIAL INSTRUCTIONS				
RELEASER	TYPED NAME TITLE OFFICE SYMBOL AND PHONE					SECURITY CLASSIFICATION			DATE TIME GROUP	
	SIGNATURE									
DD FORM 1 MAR 79 173/2 (OCR)			PREVIOUS EDITION IS OBSOLETE S/N 0102 LF 000 1735				* U.S. GOVERNMENT PRINTING OFFICE 1980-133 226			E 2193 32

Figure 13-5.—Naval Message, MILSTRIP Requisition.

Message Requisition

In certain urgent situations you may have to prepare a message requisition, because use of manual requisitions will not guarantee the delivery of material by a required time.

A message requisition will contain no more than seven single line items. For each item, a

separately numbered paragraph is required. Data blocks are separated by a virgule (/) and contain either the applicable code or the abbreviation "BLNK" for data blocks that are NOT applicable to the requested item. The virgule simply separates the coded entries and makes the message easier to read. Figure 13-5 shows a message requisition; figure 13-6 identifies the data blocks represented in the message.

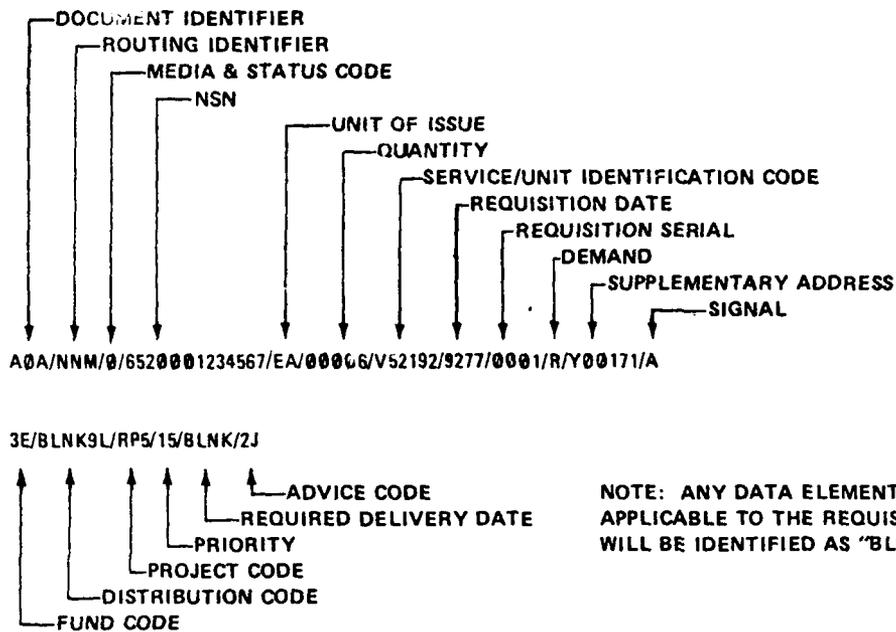


Figure 13-6.—Breakdown of MILSTRIP requisition data.

1 REQ DATE 7155	2 DEPT NO	3 URGY	4 RDC	5 LOCATION	6 SIM <input type="checkbox"/>	NON SIM <input type="checkbox"/>	7 ISSUE DATE	8 REGR NO 7155-0001									
8 NOUN NAME OR REF SYM		9 FPR	10 APL AEL CID		11 INV QTY	12 NIS <input type="checkbox"/>	N/C <input type="checkbox"/>	C OBI AMT	D POSTED								
JOB CONTROL NUMBER				13 UIC	14 WC	15 JSN	16 EIC	17 CHIP CO-AL SUPPT D YES <input type="checkbox"/> NO <input type="checkbox"/>	E URG <input type="checkbox"/>	MART <input type="checkbox"/>	S R ISSUE!						
18 SC	19 C	20 MCC	21 FPC	22	23	24 U/I	25 QUANTITY PG 0006	26 UNIT PRICE	27 EXTENDED PRICE	28 FUND							
29 REMARKS Used for necessary exception data that might be required to process the requisition.								30 APPROVED BY									
								31 RECEIVED BY									
A01	NDZ	T	000	V	52192	7155	0001	R	V	05851	A	9L	RP5	15	2J		
DOC IDENT	RTG IDENT	M & S	S	S	UIC	JUL DATE	SERIAL	C	S	SUPPL ADDRESS	S	F	DIST	PRQ	PRI	RDC	ADV

SINGLE LINE ITEM CONSUMPTION/REQUISITION DOCUMENT (MANUAL)
 NAVSUP FORM 1250-1 (7 PT) REV 12/76) S/N 0108 LF 412506

Figure 13-7.—Single Line Item Consumption Requisition Document (Manual) (NAVSUP 1250-1).

Single Line Item Consumption/Requisition Document (Manual), NAVSUP Form 1250-1

NAVSUP Form 1250-1 is a seven-part multipurpose form made of carbonized paper (requires no interleaved carbons). It is a manual MILSTRIP requisition document used by nonautomated ships to procure material or services from a tender, stock points, or the Navy

Publications and Forms Center. Figure 13-7 is an example of the NAVSUP Form 1250-1.

Order for Supplies or Services/Request for Quotations, DD Form 1155

DD Form 1155 is used for non-NSN items as follows:

Delivery Orders are used against government sources of supply (e.g., VA, GSA contracts,

Federal Prison Industries, and Institutes for the Blind/Handicapped).

Purchase Orders (PO) are used for open market purchases. A PO is issued to a commercial contractor/vendor who has no government contract. Refer to figure 13-8.

**Non-NSN Requisition (4491),
NAVSUP Form 1250-2**

NAVSUP Form 1250-2 (figure 13-9) is a seven-part, multipurpose form used as a requisition/consumption reporting document by

CHECKED BOX APPLIES <input checked="" type="checkbox"/>		REQUISITION INFORMATION		PAGE 1 OF 1																																	
V797P-3011g		N66022-87-F-0201		87 MAR 16																																	
NAVAL DENTAL CLINIC BOX 147 NAVAL STATION SAN DIEGO, CA 92136-5147 GRETCHEN MORRISON (619) 235-1922/23		N66022		X66022-7075-0001																																	
NAME AND ADDRESS BRASSELER USA INC 800 KING GEORGE BLVD SAVANNAH, GA 31405 ATT: ORDER DEPT (800) 841-4522		87 APR 17		C-9b																																	
NAVAL DENTAL CLINIC BLDG #3231 NAVAL STATION SAN DIEGO, CA 92136-5147		N66022		N00244																																	
1% DISCOUNT TERMS 1%-20 DAYS		SEE BLOCK #6		MARK ALL PACKAGES AND PAPERS WITH CONTRACT OR ORDER NUMBER																																	
<p>XX</p> <p>Summarize the following on terms specified herein, including for U.S. purchases</p> <p>INCORPORATED AND NOT TO BE THIS BOX</p> <p>and terms as indicated. This purchase is negotiated under authority of</p>																																					
<table border="1"> <thead> <tr> <th>ITEM NO.</th> <th>QUANTITY</th> <th>UNIT PRICE</th> <th>AMOUNT</th> </tr> </thead> <tbody> <tr> <td>AA 1771</td> <td>4,188H</td> <td>000</td> <td>068056 0</td> </tr> <tr> <td colspan="4"> <table border="1"> <thead> <tr> <th>ITEM NO.</th> <th>QUANTITY</th> <th>UNIT PRICE</th> <th>AMOUNT</th> </tr> </thead> <tbody> <tr> <td>0001</td> <td>#256-302, Diamond Bur, 6's</td> <td>5</td> <td>PG 18.18 90.90</td> </tr> <tr> <td>0002</td> <td>#256-303, Diamond Bur, 6's</td> <td>1</td> <td>PG 18.18 18.18</td> </tr> <tr> <td colspan="3"></td> <td>PLUS TRANS</td> </tr> <tr> <td colspan="3"></td> <td>\$109.08</td> </tr> </tbody> </table> </td> </tr> </tbody> </table>						ITEM NO.	QUANTITY	UNIT PRICE	AMOUNT	AA 1771	4,188H	000	068056 0	<table border="1"> <thead> <tr> <th>ITEM NO.</th> <th>QUANTITY</th> <th>UNIT PRICE</th> <th>AMOUNT</th> </tr> </thead> <tbody> <tr> <td>0001</td> <td>#256-302, Diamond Bur, 6's</td> <td>5</td> <td>PG 18.18 90.90</td> </tr> <tr> <td>0002</td> <td>#256-303, Diamond Bur, 6's</td> <td>1</td> <td>PG 18.18 18.18</td> </tr> <tr> <td colspan="3"></td> <td>PLUS TRANS</td> </tr> <tr> <td colspan="3"></td> <td>\$109.08</td> </tr> </tbody> </table>				ITEM NO.	QUANTITY	UNIT PRICE	AMOUNT	0001	#256-302, Diamond Bur, 6's	5	PG 18.18 90.90	0002	#256-303, Diamond Bur, 6's	1	PG 18.18 18.18				PLUS TRANS				\$109.08
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Figure 13-8.—Order for Supplies or Services/Request for Quotations (DD Form 1155).

nonautomated ships to procure non-NSN materials.

Requisition and Invoice/Shipping Document, DD Form 1149

DD Form 1149 (figure 13-10) is used to procure only material excluded from MILSTRIP and

material for which no other procurement document is specified. This form is also used to requisition repair or rental of labor-saving devices (e.g., typewriters, word processors), repair of other equipage items, dry cleaning/laundry services. When the DD Form 1149 is used, it will be limited to a single page and must be prepared by typewriter or ball-point pen.

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Figure 13-9.—Non-USN Requisition (4491) (NAVSUP Form 1250-2).

SHIPPING CONTAINER TALLY → 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

REQUISITION AND INVOICE/SHIPPING DOCUMENT

FROM: Dental Supply, Naval Dental Clinic, San Diego, CA 92136-5147
 Branch Dental Clinic, Yuma, AZ 85369-5009

TO: **RECIPIENT'S NAME AND ADDRESS**
 N. L. HARRIS, (C), MSC, JMSN
 15

DATE: 29 JUN 1987
 REGISTRATION NO: MF6022/7155/0001

QUANTITY: 12
 UNIT: BT
 AMOUNT: \$16.50

1. PYRO-PLAST, liquid, 12 oz.
 Suggested Source of Supply: Williams Dental Supply CO.
 123 Lincoln Road
 Washington, DC 20397

TOTAL COST: \$16.50

DD FORM 1149 (9-PT) 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
 REPLACES EDITION OF 1 MAY 58 WHICH MAY BE USED
 SIN-OIG LE O-11 1801

ORIGINAL

Figure 13-10.—Requisition and Invoice/Shipping Document (DD Form 1149).

BLANKET PURCHASE AGREEMENT (BPA)

The BPA method of purchase is a simplified procedure for establishing charge accounts with qualified sources of supply to cover anticipated small purchases of similar items. BPAs eliminate the need for individual purchase orders and provide a method for telephone purchase. Calls are made only by authorized personnel. Normally, someone other than the caller receives, inspects, or accepts delivery. You must obtain a receipt for the material received.

IMPREST FUNDS

An imprest fund provides a simple economical way to purchase materials. It is a cash fund used to make small payments at the time of a transaction, much like a petty cash fund in a civilian business. Reimbursements of these funds are made on a revolving basis.

The imprest fund cash is kept by a person known as the imprest fund cashier. The maximum amount allowed per transaction is \$500. Naval activities with purchasing authority are authorized to establish an imprest fund upon approval, in

writing, by the regional contracting office and the commanding officer.

Transactions when an imprest fund may be used include emergency requisitions from local sources or payment for cash on delivery (COD).

RECEIPT AND ISSUE CONTROL

Once supplies have been ordered and received, it is important to monitor the receipt and issue of storeroom supplies. The system used is determined by clinic size and number of dental officers and technicians assigned. When there are more than three dental officers, a supply issue record system must be used in order to establish usage rates and levels of supply.

This section discusses receipt and issue procedures that use stock record cards and inventory control procedures.

DOD SINGLE LINE ITEM RELEASE/ RECEIPT DOCUMENT, DD Form 1348-1

The DD Form 1348-1 is a receipt document prepared by the activity shipping the material (figure 13-11). It contains the same information

DOC NO	BY	DATE	STOCK NUMBER	QUANTITY	DOCUMENT NUMBER	SERIAL	SUPPLEMENTARY ADDRESS	FUND	DISTRIBUTION	PROJECT	REQD DATE	ADVICE	ET	UNIT PRICE
A01	NDZT	6520	001234567	PG 00001	N 66022	7155 0001	N 39354	B 2S	9L	RP5	15			0000385
SHIPPED FROM				SHIP TO				MARK FOR		PROJECT		TOTAL PRICE		
A N0244 NSC SAN DIEGO, CA				B N66022 NDC SAN DIEGO, CA				C		D		E 0000385		
WAREHOUSE LOCATION		TYPE OF CARGO	UNIT PACK	UNIT WEIGHT	UNIT CUBE	U F C	N M F C	FREIGHT RATE	DOCUMENT DATE	MAT CODE	QUANTITY			
SUBSTITUTE DATA ITEM ORIGINALLY REQUESTED													FREIGHT CLASSIFICATION NOMENCLATURE	
U ITEM NOMENCLATURE													V	
W #557 Bur, AHP, Tungsten Carbide													Y	
SELECTED BY AND DATE		TYPE OF CONTAINERS		TOTAL WEIGHT		RECEIVED BY AND DATE		INSPECTED BY AND DATE						
PACKED BY AND DATE		NO OF CONTAINERS		TOTAL CUBE		WAREHOUSED BY AND DATE		WAREHOUSE LOCATION						
REMARKS														
AA FIRST DESTINATION ADDRESS				CC DATE SHIPPED				DD				EE		
FF TRANSPORTATION CHARITABLE TO				HH LADING A&B OR RECEIVER'S SIGNATURE AND DATE				JJ RECEIVER'S DOCUMENT NUMBER				KK		
EDITION OF 1 JAN 64 MAY BE USED UNTIL EXHAUSTED													DOD SINGLE LINE ITEM RELEASE-RECEIPT DOCUMENT	

Figure 13-11.—DOD Single Line Item Release/Receipt Document (DD Form 1348-1).

9L		6520-00-123-4567			BX	3.85	DENTAL USE			01-123	40	20							
COG NO		NATIONAL STOCK NO			SMIC	DESCRIPTION	U/I	UNIT PRICE	APL/AEL NO			LOCATION	HL	LL	SL				
REQUISITIONS OUTSTANDING		A/L QTY	AT	E/R/C	BEG MO	DEM	QSBF	DATE	APR	EQI	CI	MLC	HU	BCC	SLC	PED	7-4	PS	DEM QTY
JUL DATE	SERIAL NO	QUANTITY	DATE & SER/WCC		RECEIPTS	ISSUES	ON HAND	DATE & SER/WCC		RECEIPTS	ISSUES	ON HAND							
			7005 BF				39												
			7009-0129			3	36												
7048	0001	12	7083-0004			7	29												
			7085/7048-0001		6		35												
9L		6520-00-123-4567			BX	3.85	DENTAL USE			01-123	40	20							
COG NO		NATIONAL STOCK NO			SMIC	DESCRIPTION	U/I	UNIT PRICE	APL/AEL NO			LOCATION	HL	LL	SL				

Figure 13-12.—Stock Record Card, Afloat (NAVSUP Form 1114m).

as that on the DD Form 1348. It provides documentation for both release of material by the supply source and receipt by the requisitioner.

The appropriate NDC supply department is responsible for receiving supplies for all dental facilities in a geographical region. Supply personnel inspect the supplies to verify receipt and to determine the condition of the materials. The materials are then either picked up by or delivered to the ordering dental facility, where files are updated. This includes removing the requisition from the Outstanding Requisition File, recording receipt on the invoice and requisition, and posting the receipt to the stock record cards.

STOCK RECORD CARDS

To establish usage rates, there must be a system to provide:

- A record of the material on order
- A record of materials received, and
- A record of materials issued

Use of stock record cards is the manual process for recording receipt and issue of supplies. Many activities use computer systems to record this information. Even though your supply department uses a computer system, you should use stock record cards as a backup.

The two stock record cards most commonly used for recording usage data are the NAVSUP Forms 1114m and 766.

Stock Record Card Afloat, NAVSUP Form 1114m

Figure 13-12 shows a completed NAVSUP Form 1114m. Transactions entered on this form are explained below:

- 7005 BF - This entry indicates that on the 5th day of 1987 a balance of 39 packages of the item was brought forward from a previous stock record card.
- 7009-0129 - This entry indicates that 3 units were issued on the 9th day of 1987. This issue was accomplished on document serial number 0129, reducing the balance on hand to 36 units.
- 7048-0001-12 - This entry indicates that on the 48th day of 1987 requisition serial 0001 was prepared, requesting 12 units of the item.
- 7083-0004 - This entry indicates that 7 units were issued on the 83rd day of 1987. This issue was accomplished on document serial 0004 and reduced the balance on hand to 29 units.

SECURITY PROCEDURES

In any supply department, certain security measures must be followed to prevent loss of material through pilferage. All supply storerooms must be kept locked when unattended, and only authorized personnel should be allowed in the storage area. Personnel in charge of these spaces are responsible for ensuring appropriate security.

Items such as controlled drugs and grain alcohol require special security and inventory procedures. These procedures are outlined in Chapter 21 of the *Manual of the Medical Department (MANMED)*. Local instructions give information on internal security procedures for specific items (e.g., hypodermic needles, syringes, linen, precious metals).

SAFETY PROCEDURES

Dangerous materials include all types of compressed gases, flammable liquids, and any other item that could be considered a fire hazard. These items must be stowed in an approved flammables locker. This locker is usually located outside a building in a well-ventilated area, away from direct sunlight. Proper storage of dangerous materials is especially critical aboard ships.

All compressed gas cylinders (e.g., oxygen, nitrogen, and nitrous oxide) must be secured by chains, clamps, or straps in an upright position. Special precautions should be taken to prevent cylinders from being dropped or forcefully struck against hard surfaces. Do not drag or slide cylinders. Be sure all cylinders have valve protection caps securely attached.

NOTE: The released energy from a snapped-off valve could cause a cylinder to behave like a missile.

SUMMARY

An efficient dental supply department can determine the effectiveness of operation of an

entire dental facility. As an advanced dental assistant working in a supply department, you must become familiar with all aspects of supply procurement, issuance, receipt, inspection, storage, inventory control, safety, and security.

It is important for the advanced dental assistant to remember that the Navy Supply System services many customers and is constantly undergoing updates and changes. Thus, it is very important that you keep track of the most current information provided for all supply procedures.

REFERENCES

BUMED Instruction 6700.13 series, *Authorized Medical/Dental Allowance Lists for U.S. Naval Vessels, Fleet Marine Force and other elements of the Operating Forces; Maintenance and Distribution of*, August 1975

Manual of the Medical Department, NAVMED P-117, (through change 101), July 1987

AFLOAT Supply Procedures, NAVSUP P-485, December 1985 (through change 3 to revision 1)

MILSTRIP/MILSTRAP Manual, NAVSUP P-437, April 1986

Navy Supply Acquisition Regulation Supplement (SUPARS), NAVSUP P-560, November 1985

Supply Ashore, NAVSUP P-1, Vol. II

Marine Corps Order 6700.2 series, *Medical and Dental (Class VIII) Material for Support of the Fleet Marine Force*, February 1982

CHAPTER 14

PROPERTY MANAGEMENT

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify the different classes of plant property.
2. Identify plant/minor property by dollar value.
3. Identify inventory procedures for plant property.
4. Identify survey procedures for government property.

INTRODUCTION

As an advanced dental assistant, you may be responsible for managing plant and minor property items. This includes tagging the items, conducting inventories and surveys. By properly managing the plant and minor property under your control, you can determine when it should be replaced.

This chapter covers the different classes of plant property, monetary value of both plant and minor property, inventory control, and survey procedures.

PLANT PROPERTY

Plant property includes both *real property* (land, buildings, and improvements) of a capital nature owned by the Navy or for which the Navy is accountable, and *personal property* of a capital nature owned by the Navy (e.g., dental or x-ray units). It does not include equipment designated as minor property, discussed later in this chapter.

PLANT PROPERTY CLASSES

For management, financial, and technical control purposes, plant property items are divided into four classes:

- **Class 1** is land, either owned by the Navy, or used by the Navy but owned by a state or some other federal agency.
- **Class 2** includes buildings, structures, and utilities. Buildings and structures may be either owned by the Navy or granted for use by the Navy either partially or totally. Utilities include steam systems, water supply systems, natural or manufactured gas systems, and compressed air systems.
- **Class 3** is equipment other than industrial plant equipment. It includes all Navy-owned personal property of a capital nature with an estimated or actual initial acquisition cost of \$5,000 or more. To be classified as Class 3 plant property, an equipment item must meet the following criteria:
 1. It must have an expected normal useful life of 2 years or more.
 2. It must be used in conjunction with the activity's assigned mission.
 3. It must not be altered beyond its designated capabilities.
 4. It must not be consumed in performance or work.
 5. It must not be in an inventory account of the supply system.
 6. It must not, by nature of its installation or usage, form an integral part of a Class 2 property item.
- **Class 4** is industrial plant equipment—with an acquisition cost of \$5,000 or more.

PLANT PROPERTY ACCOUNTING

Accounting procedures for plant property provide controls essential for compliance with statutory and Department of Defense requirements concerning government property. They provide a Navy-wide system of collecting, compiling, recording, and reporting plant property information. The system ensures that factual information on capital property is available for management and technical purposes.

Statutory regulations require that records on fixed property, installations, and major equipment items be maintained on a quantitative and financial basis. Additionally, the Department of Defense has issued instructions to report items meeting certain capital dollar criteria. Under these guidelines, the policy of the Department of the Navy establishes that all items of a capital nature must be recorded and reported in the Plant Property Account. The term "plant property account" refers to the records of Navy-owned plant property maintained by the fiscal office of your command. Most plant property equipment that will be recorded and reported at any DTF will be Class 3 plant property.

Recording and Reporting Class 3 Plant Property

All Class 3 items must be reported for inclusion in the Capital Asset Account of the Navy. DOD Property Record, DD Form 1342, figure 14-1, is the only form used for this purpose. A separate DD Form 1342 is prepared for each equipment item. These forms are prepared by dependent activities when property is acquired and submitted promptly to the fiscal officer of the accountable activity (e.g., Branch Dental Clinic, North Island, CA, submits completed 1342s to the fiscal officer at Naval Dental Clinic, San Diego, CA).

Computer generation of DD Form 1342 is authorized provided that all data elements are included in the same order as on the form. To report the acquisition of a Class 3 plant property, complete the DD Form 1342 using the block-by-block descriptions below:

- Block 1 - Active, Initial, Idle, Change. Insert an "X" in the "Active" and "Initial" blocks to show an item being reported into the inventory.
- Block 2 - Julian Date. Enter the Julian date that the form is prepared.

- Block 3 - ID/Government Tag Number. Enter the complete plant property identification number assigned to the item.
- Block 4 - Commodity Code. Enter the appropriate 4-digit FSC code (e.g., 6525, x-ray equipment).
- Block 5 - Stock Number. Enter the national stock number when known.
- Block 6 - Acquisition Cost. Enter the acquisition cost in whole dollars. The acquisition cost includes standard attachments procured and delivered with the basic unit.
- Block 7 - Type Code. Enter "4" to indicate Class 3 plant property.
- Block 8 - YR of MFG. Enter the last two digits of the year in which the item was manufactured. ("Not available" will NOT be used.) If the year is estimated, insert "E" immediately preceding the entry.
- Block 9 - Power Code. Enter the 2-digit operating power code. This represents the type of electrical power required to operate the item being reported. These codes are listed in *NAVCOMPT Manual, Volume III*, Chapter 6.
- Block 10 - Status Code. Enter the appropriate status code (e.g., 1A identifies Class 3 and Class 4 plant property in active use located at a naval shore activity). Additional status codes are listed in *NAVCOMPT Manual, Volume III*, Chapter 6.
- Block 11 - SVC (service code). Enter "1" to designate Navy."
- Block 12 - Command Code. Enter "N00018," the Department of Defense Activity Accounting Code (DODAAC) for Naval Medical Command. The "N" represents Navy, and 00018 is the UIC for Naval Medical Command.
- Block 13 - Admin Office Code. Enter the DODAAC of the fiscal office that has plant property accountability for the activity in possession of the item.

DOD PROPERTY RECORD		<input checked="" type="checkbox"/> ACTIVE <input checked="" type="checkbox"/> INITIAL <input type="checkbox"/> IDLE <input type="checkbox"/> CHANGE	2. JULIAN DATE 7142	3. I.D./GOVERNMENT TAG NO 68409-001005	Form Approved OMB No. 22-R0209	
SECTION I - INVENTORY RECORD						
4. COMMODITY CODE 6520	5. STOCK NUMBER	6. ACQUISITION COST \$7200	7. TYPE CODE 4	8. YR OF MFG 86	9. POWER CODE 11	10. STATUS CODE 1A
14. NAME OF MANUFACTURER Ticonium, Inc.		15. MFR'S CODE 20750	16. MANUFACTURER'S MODEL NO 3001-D1		17. MANUFACTURER'S SERIAL NO 377	
18. LENGTH 3	19. WIDTH 3	20. HEIGHT 6	21. WEIGHT 800	22. CERTIFICATE OF NON-AVAILABILITY NUMBER	23. REP NO	24. AID
						25. CONTRACT NUMBER N68409-87-M-0473
26. DESCRIPTION AND CAPACITY MACHINE CASTING TICONIUM FSC 6520, 29INLGX30INWX68INH Two shelf, stainless steel cooling rack attached to oven 16INWX24INHX8IND						
CONTINUED ON REVERSE SIDE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
SECTION II - ELECTRICAL CHARACTERISTICS						
27. QUANTITY 1	HORSEPOWER	VOLTS 115	PHASE 1	CYCLE 60	AC X	DC
						TYPE AND FRAME NUMBER
28. PRESENT LOCATION Naval Dental Clinic Area Dental Laboratory, Headquarters San Francisco, CA 94130-5030						
						28b. DPEC CONTROL NO.
						29. POSSESSOR CODE 68409 (2742 775)
SECTION III - INSPECTION RECORD						
				YES	NO	
30. CAN THIS BE STORED AND MAINTAINED ON SITE FOR AT LEAST 2 MONTHS?						42. MUST ITEM BE REPAIRED, REBUILT, OVERHAULED TO PERFORM ALL FUNCTIONS?
31. HAS ITEM BEEN REBUILT/OVERHAULED? IF YES, DATE						43. DO QC RECORDS INDICATE SATISFACTORY PERFORMANCE? IF NO, EXPLAIN UNDER REMARKS BELOW
32. HAS ITEM BEEN WIPED TO REVEAL ORIGINAL CONFIGURATION? IF YES, EXPLAIN UNDER REMARKS BELOW						44. ARE MANUALLY OPERATED MECHANISMS IN WORKING ORDER? IF NO, DESCRIBE UNDER REMARKS BELOW
33. WAS ITEM INSPECTED UNDER POWER? IF NOT, EXPLAIN UNDER REMARKS BELOW						45. ARE SCALES, DIALS, AND GAUGES WORKING AND READABLE? IF NO, DESCRIBE UNDER REMARKS BELOW
34. ARE MAINTENANCE LOGS NORMALLY NOT EXPLAIN UNDER REMARKS BELOW						46. ARE HYDRAULIC PUMPS, VALVES, AND FITTINGS OPERATING PROPERLY? IF NO, DESCRIBE UNDER REMARKS BELOW
35. ARE ALL ELECTRICAL TESTS DATE AND SATISFACTORY? IF NOT, EXPLAIN UNDER REMARKS BELOW						47. ARE ELECTRONIC SYSTEMS AND CONTROLS OPERATING PROPERLY? IF NO, DESCRIBE UNDER REMARKS BELOW
36. ARE INSTALLATION INSTRUCTIONS AVAILABLE FOR TRANSFER?						48. HOW MANY HOURS WAS ITEM USED BY CURRENT POSSESSOR?
37. ARE OPERATING INSTRUCTIONS AVAILABLE FOR TRANSFER?						49. EXPLAIN UNDER REMARKS LAST USE OF EQUIPMENT DESCRIBED IN ITEM 26 ABOVE
38. WAS ITEM LAST USED ON A FINISHING OPERATION?						50. ESTIMATED COST FOR PACKING, CRATING, HANDLING
39. WILL ADJUSTMENTS OR CALIBRATION CORRECT DEFICIENCIES?						51. INDICATE DATE ITEM WILL BE AVAILABLE FOR REDISTRIBUTION
40. IS ITEM SEPARABLE WITHOUT DAMAGE TO COMPONENTS? IF NOT, USE THE REPAIRMENT COST						52. CONDITION CODE A1
41. IS ITEM IN OPERABLE CONDITION?						53. OPERATING TEST CODE
SECTION III - REMARKS						
34. JON: 4CDAPW Requisition #: N68409-6288-0004						
REMARKS CONTINUED ON REVERSE SIDE <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
SECTION IV - DISPOSITION RECORD						
54. CONSIGNEE (NAME AND ADDRESS, INCLUDING ZIP CODE)			55. TYPE OF DISPOSITION <input type="checkbox"/> DONATION <input type="checkbox"/> DESTRUCTION <input type="checkbox"/> SALE <input type="checkbox"/> ABANDONMENT		56a. DATE OF DISPOSITION AND PROCEEDS IF SOLD	
SECTION V - VALIDATION RECORD						
57. VALIDATION (TYPED NAME(S) AND SIGNATURE(S)) C. S. STEVENS, Supply Officer						

Figure 14-1.—DOD Property Record (DD Form 1342).

- Block 14 - Name of Manufacturer. Enter the name of the manufacturer (e.g., ADEC, Ticonium, Pelton Crane). If the manufacturer cannot be determined, enter "unknown."
- Block 15 - Manufacturer's Code. Enter the 5-digit manufacturer's code listed in the *Defense Logistics Agency Handbook (DLAH) 4215* series.
- Block 16 - Manufacturer's Model Number. Enter the manufacturer's model, style, or catalog number of the equipment being reported. Always use the model number if available. When the manufacturer does not assign a model, style, or catalog number, enter the word "none."
- Block 17 - Manufacturer's Serial Number. Enter the serial number assigned by the manufacturer of the item. If the item has no serial number, enter the word "none."
- Blocks 18, 19, 20 - Dimensional Data. Enter the length, width, and height of the item. All measurements shall be to the next foot, including the skid (pallet). Dimensions on boxed items are to the next foot only. Since all dimensions are entered by foot, the use of symbols or abbreviations to designate feet are not required.
- Block 21 - Weight. When the weight of the item is not known, enter the estimated weight. For items over 500 pounds, round off to the next 100 pounds; for items under 500 pounds, round off to the nearest 10 pounds. Weight includes accessories and attachments.
- Block 22 - Certificate of Nonavailability Number. Because this is restricted to new procurement of Class 4 items only, it does not apply to Class 3 items.
- Block 23 - ASOD Number. When applicable, enter the Assistant Secretary of the Navy (shipping and logistics) approved plant equipment package number.
- Block 24 - ARD. Leave blank
- Block 25 - Contract Number. Enter the contract or purchase order number under which the Class 3 item was procured.
- Block 26 - Description and Capacity. Enter a complete description of any item with an initial acquisition cost of \$5,000 or more, including the noun name, major group, class, subclass, type, subtype, size group, and specific size. This description is determined by a physical inspection of the item by qualified personnel. If additional space is required, use block 54 or attach a continuation sheet. If you use a continuation sheet, also include the following: date, noun name, commodity code, model code, manufacturer's code, and identification number.
- Block 27 - Electrical Characteristics. Enter the quantity of each type and electrical characteristics of all motors. List main motors first.
- Block 28 - Present Location. Enter the name and location (street address, city, and state) of the activity in possession of the item. If there is no street address, insert "no street address."
- Block 28a - DIEPC Control Number. Enter the UIC followed by, in parentheses, the 7-digit number of the activity in possession (block 28). Obtain this 7-digit number from the Catalog of Naval Shore Activities. If no activity number is assigned, enter the UIC of the possessing activity. Enter sufficient zeros to the left of the UIC to make up a 7-digit number, e.g., 0039354.
- Blocks 30 through 51 - Leave blank.
- Block 52 - Condition Code. Enter the applicable condition code for the item being reported. Condition codes are listed in NAVCOMPT Manual, Volume III, Chapter 6.
- Block 53 - Operating Test Code. Leave blank.
- Block 54 - Remarks (e.g., purchase action). Enter the job order number, requisition number, and/or purchase order number under which equipment was purchased.

- Blocks 55, 56, and 56a. Leave blank
- Block 57 - Validation. Enter the name and title of the individual responsible for furnishing the technical information for the DD Form 1342.

Any additional information, including list of required codes used when preparing this form, may be obtained from *NAVCOMPT Manual, Volume III, Chapter 6*.

Correction of Class 3 DOD Property Records

To correct a previously submitted DOD Property Record, prepare a new DD Form 1342 or draw a red line through incorrect data.

These corrections are made by the holder of the item, or the holder of a previously submitted 1342. The maximum number of ink changes allowed will be 10 per record. A new property record card shall be prepared if more than 10 changes are made. Corrections are necessary for the following:

- Change in physical description of the item (e.g., addition of an accessory or auxiliary part, like a cuspidor to a dental unit)
- Change in cost data due to addition or deletion of accessory or auxiliary equipment
- Correction of the UIC
- Correction to manufacturer's name, address, model number, or serial number

Specific instruction on property record changes are listed in the *NAVCOMPT Manual, Volume III, Chapter 6*.

PLANT PROPERTY IDENTIFICATION NUMBERS

Each item of Class 3 and Class 4 plant property must be tagged with its assigned plant property identification number. This number is assigned by the fiscal officer of the accountable activity, and is the number entered in block 3 of the DD Form 1342. With the exception of those activities where an alpha designation is part of the UIC, the use of letters in the identification number is prohibited.

All identification tags must contain:

- A suitable indication of Navy ownership, such as "USN Property" or "USMC Property," or just the abbreviation "USN" or "USMC."
- An 11-digit identification number made up of two elements—the UIC of the activity where the equipment is first placed in use and a 6-digit identification suffix. For example:

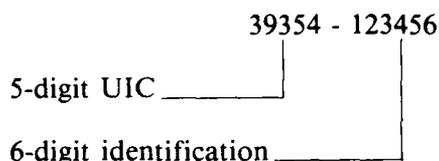


Figure 14-2 shows a typical plant property tag. Tags can be fabricated from metal, fiber, or plastic. When it is impracticable to use a tag, the item can be marked with indelible ink, acid or electrical etch, steel die, a decal, or any other legible, permanent, conspicuous, and tamper-proof method.

Although the fiscal officer assigns the numbers, always check to ensure that a suffix number is not assigned to more than one item.

INVENTORY OF PLANT PROPERTY

Every activity regardless of its size or nature, must have a physical inventory system to account for all plant property. It must provide detailed instructions for the following:

1. Purpose of the inventory
2. Responsibilities of each individual assigned to take the physical inventory
3. Specific list of inventory areas, with target dates for completion

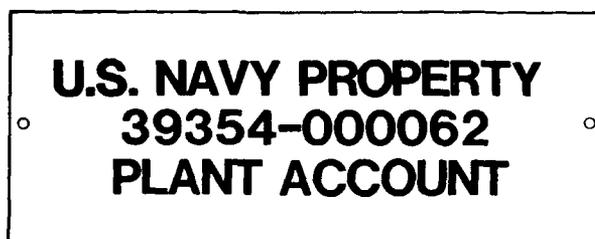


Figure 14-2.—Plant Property Identification Tag.

4. Plan for indoctrination of personnel who will conduct the inventory
5. Techniques for sighting, tagging, describing, recording, and reporting plant property items
6. Instructions for preparing an inventory progress report for local management

The Department of the Navy has set these policies for conducting physical inventories and reconciling property records of Class 3 plant property:

- They are required at least once every 3 years.
- They must be conducted and completed within time periods set forth in a schedule (e.g., the inventory year for Naval Medical Command is 1985; the inventory must be completed between 1 July 1985 and 31 March 1986).
- The fiscal office must be notified when the inventory is completed.
- The records of the holding activity must be reconciled with those of the fiscal office. Differences must be corrected after the inventory is completed.

MINOR PROPERTY

Minor property is defined as personal property acquired for immediate use and having a value of \$300 to less than \$5,000. Because minor property is classified as pilferable (e.g., furniture, office equipment, hand and portable power tools), each activity that maintains minor property items shall establish internal controls to safeguard all minor property assets.

INTERNAL CONTROLS

All activities owning minor property items will establish internal controls to accommodate the needs of that activity. Suggestions for these controls are discussed below.

- Designate a minor property custodian who is responsible for all minor property. This will normally be someone working in the supply department.

- Prepare a property management document to include:

1. Identification number (assigned locally)
2. Noun name of the item
3. Model number and serial number
4. Quantity or item count
5. Location
6. Acquisition date
7. Acquisition cost
8. Date of last inventory
9. Source document number
10. Manufacturer of item

- The minor property custodian should affix the minor property with a tag, plate, or other device. This tag will contain a unique control number that will identify each minor property item.

- Conduct an annual physical inventory.

Figure 14-3 is an example of the Report of Minor Property, NAVCOMPT Form 274. This form is completed at the command's discretion, but it is not to be prepared more frequently than once every 6 months.

SURVEY OF GOVERNMENT PROPERTY

A property survey is a procedure for determining the cause of gains, losses, or damage to Navy property. The survey process is documented and certified on a Report of Survey, DD Form 200 (figures 14-4A and 14-4B). It may also establish personal responsibility.

Previous DOD forms, Government Property Lost or Damaged (GLPD), DD Form 2090, and Report of Survey, DD Form 200 dated Dec 1972 are obsolete and will no longer be used.

Preparation of this document may vary slightly depending on the nature of the survey. Specific instructions are outlined in *NAVSUP Manual P-485*.

When a discrepancy is due to paperwork or bookkeeping error, you need not prepare a DD Form 200. Simply make the proper accounting adjustments on the custody or stock record cards.

SUMMARY

Although the fiscal officer is responsible for the management of plant and minor property, the

REPORT OF SURVEY				
PRIVACY ACT STATEMENT Personal information from the individual is solicited. As required by the Privacy Act of 1974, we advise:			1. TYPE REPORT (X one) <input checked="" type="checkbox"/> a REPORT OF SURVEY <input type="checkbox"/> b GOVERNMENT PROPERTY LOSS/DESTROYED	
AUTHORITY 16 U.S.C. 136, 10 U.S.C. 1071; DoD Instruction 7200.10 PRINCIPAL PURPOSE To officially report the facts and circumstances supporting the assessment of pecuniary charges for the loss, damage, or destruction of DoD-controlled property. ROUTINE USES To initiate investigations of losses/gains of DoD-controlled property and record the findings and actions taken. DISCLOSURE IS VOLUNTARY Refusal to explain the circumstances under which the property was lost/damaged, or destroyed may be considered with other factors in determining if an individual will be held pecuniarily liable.			2. SURVEY NUMBER 0015 3. DATE LOSS/GAIN DISCOVERED (YYMMDD) 871210	
4. NATIONAL STOCK NO.	5. ITEM DESCRIPTION	6. QUANTITY	7. UNIT COST	8. TOTAL COST
	HANDPIECE, TITAN Serial #6400 Minor Prop #M051761 Mfg; STAR DENTAL	1 EA	390.00	390.00
9. CIRCUMSTANCES UNDER WHICH PROPERTY WAS (X one) (Attach additional pages, as necessary) <input checked="" type="checkbox"/> LOST <input type="checkbox"/> GAINED <input type="checkbox"/> DAMAGED <input type="checkbox"/> DESTROYED CAUSE: LOSS BY INVENTORY The item listed above was unaccounted for during the inventory held 10 DEC 87. Records indicate item was submitted to NDC Supply after Repair was unable to service the item. Date of transfer was 18 OCT 86.				
10. ACTIONS TAKEN TO CORRECT CIRCUMSTANCES REPORTED IN BLOCK 9 AND PREVENT FUTURE OCCURRENCES (Attach additional pages, as necessary) Recommended Handpiece Custodian to initiate a log to closely maintain issue/receipt of items.				
11. INDIVIDUAL COMPLETING BLOCKS 9 AND 10				
a. TYPED NAME (Last, First, Middle Initial)		b. SIGNATURE		c. DATE SIGNED
GETTY, JOHN P. DTC, USN				22 JAN 88
12. RESPONSIBLE OFFICER				
a. ORGANIZATIONAL ADDRESS (Unit Designation, Office Symbol, Base, State, Zip Code)		b. TYPED NAME (Last, First, Middle Initial)		c. AUTOVON NUMBER
NDC BOX 147, NAVSTA SDIEGO, CA 92136-5147		FIELDS, ROGER L. DTC, USN		958-2222
		d. SIGNATURE		e. DATE SIGNED
		<i>R. L. Fields</i>		22 JAN 88
13. ACCOUNTABLE OFFICER				
a. NUMBER OF DOCUMENTS USED TO ADJUST PROPERTY RECORD				
b. ORGANIZATIONAL ADDRESS (Unit Designation, Office Symbol, Base, State, Zip Code)		c. TYPED NAME (Last, First, Middle Initial)		d. AUTOVON NUMBER
NDC BOX 147, NAVSTA SDIEGO, CA 92136-5147		FRENCH, MIKE P. DTC, USN		958-2222
		e. SIGNATURE		f. DATE SIGNED
		<i>M. P. French</i>		22 JAN 88

DD Form 200, OCT 84
S/N 0102-11-000-2001

Replaces DD Form 200 83 MAY AF Form 138 JAN 83
DD Form 2090 SEP 77 and DA Form 4697 SEP 91 which are obsolete

Figure 14-4A.—Report of Survey (DD Form 200).

14 FINDINGS AND RECOMMENDATION OF SURVEY OFFICER			
a FINDINGS AND RECOMMENDATIONS (Attach additional pages, as necessary)			
RECOMMENDED FOR APPROVAL OF SURVEY			
b DOLLAR AMOUNT OF LOSS/GAIN \$390.00		c RECOMMENDED PECUNIARY CHARGE 0	d LOSS/GAIN TO GOVERNMENT \$390.00
15 SURVEY OFFICER			
a ORGANIZATIONAL ADDRESS (Unit Designation, Office Symbol, Base, State, Zip Code) NDC BOX 147, NAVSTA SDIEGO, CA 92136-5147		b TYPED NAME (Last, First, Middle Initial) J. S. JONES, LCDR, MSC, USN	c AUTOVON NUMBER 958-2222
		d DATE REPORT SUBMITTED TO APPOINTING OFFICIAL 03 JAN 88	e DATE APPOINTED
		f SIGNATURE <i>J. S. Jones</i>	g DATE SIGNED 24 JAN 88
16 INDIVIDUAL CHARGED			
a I HAVE EXAMINED THE FINDINGS AND RECOMMENDATIONS OF THE SURVEY OFFICER AND (X one)		b I AM AWARE OF MY RIGHT TO (1) LEGAL ADVICE AND (2) APPEAL IF PECUNIARY CHARGES ARE ASSESSED ENLISTED PERSONNEL HAVE THE RIGHT TO REQUEST REMISSION OF INDEBTEDNESS	
(1) SUBMIT THE ATTACHED STATEMENT OF OBJECTION			
(2) DO NOT INTEND TO MAKE SUCH A STATEMENT			
c TYPED NAME (Last, First, Middle Initial)		d SIGNATURE	e DATE SIGNED
			f AUTOVON NUMBER
17 APPOINTING OFFICIAL			
a RECOMMENDATION (X one)		b COMMENTS	
<input checked="" type="checkbox"/> (1) APPROVE			
<input type="checkbox"/> (2) DISAPPROVE			
c ORGANIZATIONAL ADDRESS (Unit Designation, Office Symbol, Base, State, Zip Code) NDC BOX 147, NAVSTA SDIEGO, CA 92136-5147		d TYPED NAME (Last, First, Middle Initial) J. M. TOTTER, CDR, MSC, USN	e AUTOVON NUMBER 958-2233
		f SIGNATURE <i>J. M. Totter</i>	g DATE SIGNED 25 JAN 88
18 APPROVING OFFICIAL			
a ACTION (X one)		b COMMENTS	
<input checked="" type="checkbox"/> (1) APPROVED			
<input type="checkbox"/> (2) DISAPPROVED			
c ORGANIZATIONAL ADDRESS (Unit Designation, Office Symbol, Base, State, Zip Code) NDC BOX 147, NAVSTA SDIEGO, CA 92136-5147		d TYPED NAME (Last, First, Middle Initial) G. R. RIVER, CAPT. DC, USN	e AUTOVON NUMBER 958-2233
		f SIGNATURE <i>G. R. River</i>	g DATE SIGNED 26 JAN 88

DD Form 200 Reverse, OCT 84

Figure 14-4B.—Report of Survey (DD Form 200) Reverse.

advanced dental assistant may be required to assist in the management process.

Plant and minor property encompasses the major equipment required to operate a dental facility. It is therefore important that you keep good accounting records and closely observe the conditions of all plant and minor property. This will help you plan for property replacement and avoid any down time in administrative work or patient care.

Property management procedures may vary at each activity, but all DTFs must follow the guidelines provided in the *NAVCOMPT Manual, Volume III*, Chapter 6, and NAVMEDCOM and local instructions.

REFERENCES

Navy Comptroller Manual, Volume III, July 1986
(through change 343)

Afloat Supply Procedures (NAVSUP P-485),
December 1985 (through change 3 to revision
1)

NAVSUP NOTICE 4440, *Reporting and*
Accounting for Gained or Lost Government
Property, December 1985

CHAPTER 15

FINANCIAL MANAGEMENT

Learning Objectives

Upon completion of this chapter you will be able to:

1. Identify terms commonly used in financial management.
2. Identify how funds are appropriated and the appropriation categories.
3. Identify budget preparation procedures.
4. Identify budget calls for a dental activity.
5. Recognize the value and procedures for investment equipment budgeting.
6. Identify OPTAR recordkeeping and accounting procedures.

INTRODUCTION

Whether working in the financial management department at a large dental treatment facility (DTF) or maintaining a small operating budget at a branch facility or dental department aboard ship, the advanced dental assistant must have a working knowledge of financial management.

The Department of the Navy allocates funds that enable each dental activity to accomplish its mission. Before you can take part in financial management at the dental activity level, you must understand where the funds originate and how they are distributed. But before you can understand this process, you need to know the terms used in financial management. The most common terms are explained in the following section.

FINANCIAL MANAGEMENT TERMS

ALLOCATION.—An assignment of funds to a specific purpose or account.

APPORTIONMENT.—A determination of the amount of obligations that may be incurred during a specific period. Annual appropriations of funds are distributed over 3-month periods

called fiscal quarters. An apportionment regulates the rate at which those funds may be spent throughout the year.

APPROPRIATION.—The setting aside of a specific amount of funds to be used for a designated purpose. These funds (appropriations) are divided into budget activities and further divided into subactivities, programs, projects, and elements of expense. The Department of the Navy appropriations are classified into three types:

- Annual or 1-Year Appropriations - These funds are available for incurring obligations only during the Fiscal Year specified in the Appropriation Act. Example: Operation and Maintenance, Navy (O&MN) - These appropriations provide funds to finance the cost of day-to-day operations and maintenance of the Navy. The funds pay for salaries and fringe benefits of civilians, contracts for maintenance of equipment and facilities, fuels, supplies, and repair parts. For most activities, the appropriations provide funds in support of the operating budget, which is the master financial planning and control document for accomplishing the command's mission. If these funds are not obligated in that year, they automatically

revert back to the grantor of the funds at the end of that fiscal year.

- **Multiple Year Appropriations** - These funds are available for incurring obligations for a definite period in excess of one fiscal year. The Navy and Marine Corps may receive multiple-year appropriations for construction projects that will take over 1 year to complete. Example: Other Procurement, Navy (OPN) - OPN funds are commonly used within medical/dental activities for purchasing investment equipment (equipment having a value of \$5,000 or more) that is not assigned a National Stock Number (NSN).
- **Continuing or No-Year Appropriations** - These funds are available to support projects that have an indefinite completion date (e.g., shipbuilding, public works construction, and research and development). These appropriations are available until they are used up or until the Navy accomplishes the purpose for which they were intended.

APPROPRIATION ACT.—A congressional law that authorizes the spending of Treasury money.

BUDGET.—An overall financial plan of action.

COMMITMENT.—A firm administrative reservation of funds. Entering into a commitment is usually the first step in the process of spending available funds.

EXPENDITURE.—Disbursement of available funds. Expenditures are evidenced by vouchers, claims, or other documents approved by competent authority.

FISCAL YEAR (FY).—The period between the annual balancing of financial accounts and the next annual balancing period. The Federal Government uses this annual accounting period,

which is different from the calendar year. The Federal Government's fiscal year begins on 1 October of one year and ends on 30 September of the following year. It is named for the calendar year in which it ends. For example, the fiscal year 1987 (FY87) began on 1 October 1986 and ended on 30 September 1987. This accounting period is called FY87 because the accounting period ended in 1987.

Fiscal Quarters.—The fiscal year is divided into Fiscal Quarters. For example, the fiscal quarters of FY87 were:

First Quarter: 1 October 1986 to 31 December 1986
Second Quarter: 1 January 1987 to 31 March 1987
Third Quarter: 1 April 1987 to 30 June 1987
Fourth Quarter: 1 July 1987 to 30 September 1987

OBLIGATION.—The amount of funds set aside for an order placed, contract awarded, or other legally binding transaction requiring an expenditure of a specified amount of funds.

PROGRAM OBJECTIVES MEMORANDUM (POM).—A memorandum in prescribed format submitted by the Secretary of the Navy to the Secretary of Defense. The POM recommends the total resource requirements, within the parameters of the Secretary of Defense's fiscal guidance, for the operation of the Department of the Navy.

APPROPRIATION OF FUNDS

Congress provides funds through annual legislation known as the Appropriation Act. The process whereby funds flow from Congress to your DTF (figure 15-1) is the subject of the following discussion.

FLOW OF FUNDS

Congress sends the DOD Appropriations Bill to the President for signature. When signed, the bill becomes the Appropriations Act. The Office of Management and Budget (OMB) then apportions the funds to the Department of the Navy.

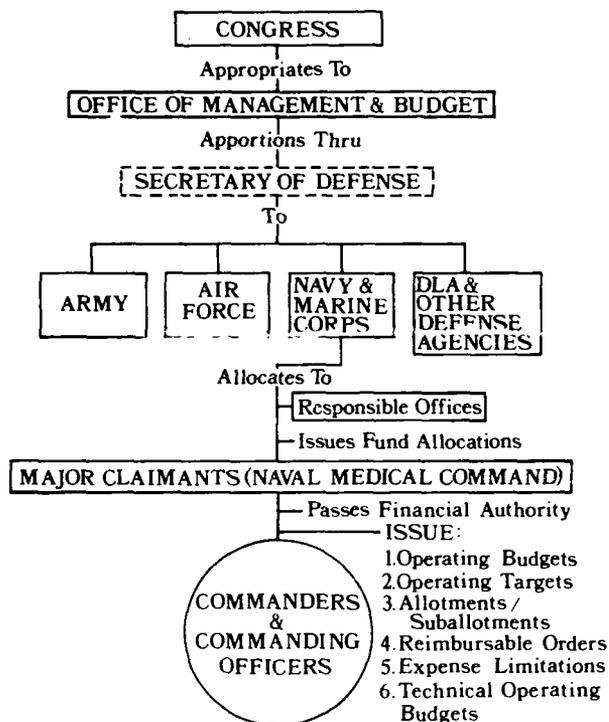


Figure 15-1.—Flow of Funds.

Under the authority of the Secretary of the Navy, the Comptroller of the Navy (NAVCOMPT) subdivides or allocates funds to major claimants (NAVMEDCOM). NAVMEDCOM then subdivides these allocations to GEOCOMS, who pass financial authority to commanders and commanding officers, who then issue operating budgets and operating targets. This makes funds available for commitment, operation, and expenditure at your activity level. This process requires that expenditures be spent in an orderly manner throughout the year to avoid the need for additional congressional appropriations.

The Budget and Accounting Act of 1921 authorizes the President to establish reserve funds to effect saving or to provide for contingencies. It is under this authority that the President, through the OMB, often withholds funds appropriated by Congress. As a result of this apportionment process, the OM&N annual appropriations are divided into four quarterly limits, not necessarily in equal amounts. It is important to remember that quarterly division of funds is as legally binding as the total limit of the appropriation itself. For example, a one million dollar appropriation may be apportioned in one

of the three ways in the table shown below, or at any other rate as determined by OMB:

APPROPRIATIONS IN THOUSANDS OF DOLLARS

	Apportionment		
	Example I	Example II	Example III
First Quarter	250	100	200
Second Quarter	250	400	200
Third Quarter	250	400	200
Fourth Quarter	250	100	400
	1,000	1,000	1,000

Obligating Appropriated Funds

Regardless of command level, obligations of appropriated funds may not be made prior to receipt of proper authorization. For example, the fiscal officer for a naval dental clinic cannot automatically obligate funds on 1 October for a new dental unit unless authorization to spend the funds has been received. Also, obligations may not exceed authorized amounts.

NOTE: At times, Congressional Appropriations may not be enacted by the beginning of the fiscal year. If this happens, a continuing resolution for the interim period will normally be approved. This authorizes obligations but limits them to the prior year's rate until the appropriation is enacted.

BUDGETING

You are now familiar with how Congress appropriates funds down to your activity level. But how does Congress determine the funds required by your activity to accomplish its mission? This is done a year in advance, through development of a budget (financial plan) for a fiscal year. Your activity budget goes to your financial management

office, where it is combined with budgets of other branch clinics to form one budget that eventually becomes part of the NAVMEDCOM budget. The NAVMEDCOM budget becomes part of the DON budget, which becomes part of the DOD budget, which ultimately becomes part of the President's budget. The President's budget is then presented to Congress for review, modification, and approval.

BUDGET CALLS

A naval dental clinic (NDC) headquarters formulates budgets and allocates appropriations for the branch clinics. The commanding officer issues a yearly budget call for cost center managers at the branch clinics to develop their operating budget estimates. These estimates must be as accurate as possible and supporting data and justification for the requested funds must be included. In the budget call, the commanding officer:

- Outlines program objectives and workload projections
- Communicates instructions and budget policy decisions based on recommendations received through command channels (e.g., branch heads, department heads, LCPO.)
- Provides information on specific budget procedures
- Provides schedules and actions required by the cost centers
- Provides approved flow of budget data from the point of origin to the review levels

OPERATING BUDGET ESTIMATE

When preparing the operating budget estimate for your activity, you must anticipate the following:

- Scheduled and unscheduled workload for the period covered; e.g., Children's Dental

Health Week or unscheduled deployments of ships and units

- Changes in staff personnel; e.g., an increase in the number of dental officers will require additional equipment and supplies
- Substantial increase in utility usage or a rise in utility rates (a drastic change in cost can result at a foreign duty station due to exchange rate variations of foreign currency)
- Building repairs
- Other special projects that will require additional funds

OPERATING BUDGET

The operating budget is constructed basically in four steps:

1. Translating the planned workload for each cost center into budget/accounting classifications (e.g., civilian and military labor hours, material requirements, and services to be performed by others).
2. Applying realistic dollar values to each budget/accounting classification within the guidelines established by the command and the Navy Comptroller (NAVCOMPT).
3. Preparing a total dollar estimate for each cost center. This total will provide each cost center with a planned operating budget for internal use.
4. Preparing the final budget for submission to higher authority.

BUDGETING FOR INVESTMENT EQUIPMENT

Shore activities under the management control of the Commander, Naval Medical Command

(COMNAVMECOM), prepare their investment equipment budgets and submit them through the chain of command to COMNAVMECOM. Investment equipment is equipment that has a unit value of \$5,000 or more. This equipment will require NAVMECOM approval prior to purchase, and when received at your command, it is tagged and recorded as plant property. Investment equipment is purchased either through O&MN funds or OPN funds. If the item requested has a National Stock Number (NSN), O&MN funds are used for procurement; if the item does not have an NSN, OPN funds are used.

Annually, in the month specified by NAVMECOM, a budget-year budget covering the next 2 years is forwarded to NAVMECOM. Negative reports are required. Each activity's requirements are incorporated into NAVMECOM's total requirements. These requirements are used by NAVMECOM to prepare the POM. The budget year input is the first opportunity an activity has to identify total investment requirements. No growth in this budget will be authorized, except for unfunded items carried over from the prior year. The opportunity to update your requirements will not occur until 18 months following the date of the original input. The budget-year includes:

- Replacement items. All items in the investment equipment inventory that will reach the end of their useful life expectancy by the end of the fiscal year in which the budget is to be executed. A life expediency guide for medical/dental equipment is provided in BUMEDINST 4235.5 series.
- New items. Items that are required as a result of increased or new mission requirements or significant changes in technology that render existing items obsolete.

Annually, in the month specified by NAVMECOM, an apportionment-year budget update is forwarded to NAVMECOM. This apportionment-year budget is an update of the budget-year budget, allowing for a roll-over of unfunded current year items. These are items that were budgeted for but are unfunded in the current year budget. It also allows you to delete or

reprioritize items requested and, if absolutely essential, to add new items over and above unfunded items carried over. For further instructions consult the current NAVMECOM directives for investment equipment.

OPERATING TARGET (OPTAR)

This section covers accounting procedures for fleet funding. Ships and commands under a type commander's control are authorized to cite his operating budget accounting data for materials and services. These funds are referred to as an OPTAR. It is SECNAV policy that the accounting effort performed by Navy Operating Forces be kept to the absolute minimum and that the responsibility for formal accounting be placed ashore. To understand your duties in afloat, it is first necessary to understand how the fleet commander, type commander, and commanding officers of ships administer and account for funds, supplies, and equipage. Under current procedures OPTAR accounting includes only supplies and equipage funds.

Fleet and Type Commanders

Funds are allocated under the appropriation O&MN to each fleet commander for procurement of supplies and equipment. Fleet commanders are responsible for the administration and accounting of all funds allocated to them. Fleet commanders issue expenselimitation operating budgets to type commanders. These budgets include funds to procure supplies and equipment for all ships under their command. Type commanders issue responsibility-center operating budgets to cover operating costs of ships, units, and staff under their responsibility.

Commanding Officers

Commanding officers are responsible for the proper and effective use of OPTAR funds. Statutes require that each transaction affecting the balance of an operating budget be recorded in official records. It is the responsibility of the ship's finance officer to maintain shipboard records that accurately show the value of chargeable

requisitions incurred against funds and to report them to the Fleet Accounting Office (FAO).

OPTAR ACCOUNTING

As mentioned above, the ship's finance officer must maintain the official shipboard OPTAR accounting records. Usually, each department maintains an unofficial record for their own use and for planning purposes. As the department's OPTAR recordkeeper, you will maintain the Requisition/OPTAR Log, NAVCOMPT Form 2155, figure 15-2. In doing so, you assume responsibility for the proper use and accounting of funds. You will post all transactions to the department's OPTAR accounting records. These records will be reviewed from time to time for completeness and accuracy.

Requisition/OPTAR Log

The Requisition/OPTAR Log, NAVCOMPT Form 2155, is the principal shipboard financial control document. The individual maintaining it is known as the OPTAR Recordkeeper. Most of the columns in the OPTAR Log are self-explanatory. However, the following general rules shall be observed:

- All entries in the OPTAR Log should be in ink and legible.
- The ship's name and hull number, along with the department's name, should be written in the space provided in the upper right-hand corner of each page of the OPTAR Log.
- Each page of the log should be numbered in sequence.
- The fiscal year should be entered on each page of the log.

The operating target amounts established by your commanding officer must be entered in the Requisition/OPTAR Log. Each chargeable transaction will reduce the available funds by the value of the chargeable transactions. Not all transactions are chargeable to the OPTAR. Requisitions citing nonchargeable fund codes are recorded in the log to maintain requisition number control, although they will not have an effect on the OPTAR balance. Likewise, cost adjustments will affect the OPTAR balance. If an increase in cost

is charged, the available fund balance is reduced. If a decrease in cost is realized, the department's supply of outstanding requisitions increases. The OPTAR Log is like your personal checkbook; both start with a specific amount of money. Each check or chargeable requisition decreases your available funds. When you put money into your account or receive an increase in the OPTAR, the balance increases. The starting amount of money in the OPTAR is a grant from the commanding officer. Departments are usually notified of grants by memorandum. You must record the amount and date of the grant on the Requisition/OPTAR Log. The memorandum is filed in the departmental files in the 7000 series.

SUMMARY

As in any organization, you need money to function or accomplish a mission. Picture financial management as a pie to be divided up so everyone gets their required share or piece. In order for your command to receive its fair share, it is important to account for funds by accurate recordkeeping and to plan ahead. It would be impossible for the advanced dental assistant to determine how much money is required to accomplish the mission and come up with an accurate operating budget alone. Therefore, you must get input and assistance from all sources, i.e., dental officers, and junior dental assistants.

Financial management is a complex subject and this chapter covers only the basics. For further information, consult the various manuals and publications listed in the references at the end of the chapter.

REFERENCES

Navy Comptroller Manual, Volume 2, September 1986 (through change 321)

Navy Comptroller Manual, Volume 7, February 1986 (through change 54)

NAVMED 5020, *Resource Management Handbook*, November 1985 (through change 4)

NAVSO P-3582, *Financial Management Guidebook for Commanding Officers*, November 1985

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